Urology Services Inquiry

Oral Hearing

Day 36 – Tuesday, 18th April 2023

Being heard before: **Ms Christine Smith KC (Chair)**
Dr Sonia Swart (Panel Member)
Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

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1 THE INQUIRY RESUMED AT 10:20 A.M. ON TUESDAY, 18TH
2 APRIL 2023, AS FOLLOWS:
3
4 CHAIR: Good morning, everyone. Welcome back. I hope
5 everyone managed to get some downtime over Easter. 10:20
6 A special big welcome back to my colleagues here; it's
7 good to see them in person again.
8
9 Mr. Carroll, good morning. Mr. Wolfe.
10 10:20
11 THE WITNESS CONTINUED TO BE EXAMINED BY MR. WOLFE KC AS
12 FOLLOWS:
13
14 1 Q. MR. WOLFE KC: Good morning Mr. Carroll. Thank you for
15 coming back to us. We're starting from page 5 of my 10:20
16 speaking note.
17
18 Mr. Carroll, we last heard from you on about the 2nd
19 March. It was Day 29 of the Inquiry's hearings. The
20 transcript, for the record, for those hearings is to be 10:20
21 found from TRA-03506 - we don't need that up - through
22 to 03553.
23
24 When you were last with us, Mr. Carroll, we spent some
25 time that afternoon looking at your input into the 10:21
26 events of September 2016. You'll recall that there was
27 the first Oversight Committee or Oversight Group
28 meeting that month that led to a certain decision;
29 Mrs. Gishkori's unhappiness, if I can put it in those

1 terms, with that decision. We rounded off, I think,
2 when you told me that Mrs. Gishkori didn't want to
3 pursue the action plan that had been agreed by the
4 Oversight Committee, and you said that it would be
5 a lengthy process, or it was anticipated that it would 10:21
6 be a lengthy process, and would not necessarily have
7 a favourable outcome. The Chair picked you up on that
8 and asked what you meant by a favourable outcome,
9 a favourable outcome to whom? Thinking back on that
10 you said: 10:22
11
12 "I suppose Mrs. Gishkori wanted an outcome that allowed
13 Mr. O'Brien to work with us. And rather than being
14 viewed as being some sort of sanction or some sort of
15 punitive, that he would be happy to work alongside us". 10:22
16
17 That's where we left on the last occasion. Do
18 you agree with that?
19 A. Yes.
20 2 Q. Thank you. I want to ask you some questions about 10:22
21 whether you were aware of Mrs. Brownlee, the Chair of
22 the Trust Board, seeking to have any input or seeking
23 to make any intervention around what was going on
24 either at that time o r later. Before I ask you some
25 questions about that, can I put up on the screen some 10:23
26 pieces of information or evidence that the Inquiry has
27 received. If we can put up on the screen WIT-87673.
28 This is the witness statement of Dr. Tracy Boyce who
29 was pharmacy within the Trust?

1 A. She was the Director of Pharmacy, yes.
2 3 Q. And she had a governance role supporting Mrs. Gishkori
3 within Acute?
4 A. Correct.
5 4 Q. She has volunteered to the Inquiry the following 10:23
6 account:
7
8 "I would like to add information about a telephone call
9 that I inadvertently witnessed, as it, I think, it may
10 be evidence of some level of pressure on one of the 10:24
11 Acute Services directors who did not fully investigate
12 Mr. O'Brien's practice. I cannot remember the date of
13 the meeting and I did not make a note of the incident
14 at the time. However, I know that it must have been
15 after the concern in relation to Mr. O'Brien's triage 10:24
16 practice was identified as I understood the context of
17 the call without it having to be explained".
18
19 Paragraph 44.3:
20 10:24
21 "I was in a one-to-one meeting with Esther Gishkori,
22 Director of Acute Services, in her office on the
23 Craigavon Hospital administration floor, updating her
24 on my pharmacy responsibilities. The telephone rang
25 and Mrs. Gishkori answered it whilst I was in the room. 10:25
26 I realised she was speaking to the Chair of the Trust,
27 Mrs. Roberta Brownlee, and while I indicated to
28 Mrs. Gishkori that I would leave the room to give her
29 privacy, she told me to stay. I could not hear what

1 Mrs. Brownlee was saying, however I recall that
2 Mrs. Gishkori did not say very much in response to
3 Mrs. Brownlee during the call and that she became very
4 flustered. When the call ended, Mrs. Gishkori told me
5 that the Chair had asked her to "leave Mr. O'Brien 10:25
6 alone" as he was an excellent doctor and a good friend
7 of hers who had saved her life of one of her
8 friends" -- that might be corrected to "or" one of her
9 friends. We'll speak to Mrs. Boyce about that.
10 10:26
11 "I remember saying to Mrs. Gishkori that the Chair's
12 behaviour was unacceptable and she should document the
13 call and speak to the Chief Executive about it as her
14 line manager. I do not know if Mrs. Gishkori escalated
15 the telephone call and it was never mentioned to me 10:26
16 again".
17
18 That quote ends at WIT-8674.
19
20 If I could put one other piece into the mix before 10:26
21 I ask you some questions, Mr. Carroll. This comes from
22 the statement of Martina Corrigan. If we can have up
23 on the screen WIT-26225. She says:
24
25 "I have an awareness of at least two occasions where 10:27
26 managers had been asked to step back from managing
27 Mr. O'Brien. In approximately 2011 /2012 Mr. Mackle
28 had been advised that he was being accused of bullying
29 and harassment towards Mr. O'Brien and that he needed

1 to step back from managing him. I was not present when
2 Mr. Mackle was told this but he came straight to me
3 after this happened, told me about it, and was visibly
4 annoyed and shaken and said to me that he would no
5 longer be able to manage Mr. O'Brien". 10:27
6
7 More pertinently from your perspective, Mr. Carroll,
8 she says:
9
10 "I also understand that in mid-2016, Mrs. Gishkori 10:27
11 received a phone call from the then Chair of the Trust,
12 Mrs. Brownlee, and was requested to stop an
13 investigation into Mr. O'Brien's practice. Once again,
14 I did not witness this but I was told later by
15 Mr. Carroll that it happened as my understanding is 10:28
16 that Mrs. Gishkori had told some of her team".
17
18 Just to finalise, Mrs. Brownlee, in her statement at
19 WIT-95894, has said:
20 10:28
21 "I would never interfere". This is at 48.1. This is
22 the quote from what I've just read out. Then, just
23 scrolling down:
24
25 "This account from Martina Corrigan is third-hand. 10:29
26 Martina states that she heard from some unnamed member
27 of Esther Gishkori's team that I had asked Esther to
28 halt an investigation into Mr. O'Brien. I would never
29 interfere in due process in this way. Patient Safety

1 was always my top priority, and I have absolutely no
2 doubt that Esther will confirm that this never
3 happened. I never made any phone call to
4 Esther Gishkori about Mr. O'Brien".
5 10:29
6 Now, Mrs. Corrigan's account, Mr. Carroll, suggests
7 that you were an informant to her or other members of
8 staff in respect of what has been described here. Do
9 you recall anything resembling what I've described from
10 these statements? 10:30
11 A. Yes. So, I would have an awareness that Esther had
12 received a phone call from Mrs. Gishkori. I do think
13 it was Esther - Mrs. Gishkori - who told me. When she
14 told me exactly, I don't recall, or where she told me
15 I don't recall. But certainly Mrs. Gishkori did tell 10:30
16 me, and I think others possibly, but I wouldn't be too
17 sure of that, that she had received a phone call from,
18 allegedly, Mrs. Brownlee in regard to how Dr. Boyce
19 describes it in terms of Mrs. Brownlee's -- again, I'm
20 hearing - I'm getting this second, third-hand, I wasn't 10:30
21 there - but it was something along the lines of
22 Mrs. Brownlee speak to Mrs. Gishkori in regard to
23 Mr. O'Brien and the management of Mr. O'Brien.
24 5 Q. Just to be clear because your evidence was perhaps a
25 little uncertain in respect of elements of that. Can 10:31
26 I just maybe drill down with you.
27
28 You had the conversation with Mrs. Gishkori?
29 A. Yes.

1 6 Q. Mrs. Gishkori told you that she had received a
2 telephone call from Mrs. Brownlee?
3 A. Correct.
4 7 Q. Were you told that Dr. Boyce was present during that
5 telephone call? 10:31
6 A. No, I don't believe so. No.
7 8 Q. Okay. And you're unable to date when Mrs. Gishkori
8 told you about it?
9 A. Yes.
10 9 Q. And you're unable to date when the conversation between 10:32
11 Gishkori and Brownlee took place?
12 A. Yes.
13 10 Q. Obviously, you took over the Assistant Directorship
14 role in the spring of '16, and there are a number of
15 important events which we know took place within 10:32
16 12 months of that, including the September Oversight
17 Committee meeting, the December Oversight Committee
18 meeting, leading then on to the MHPS investigation.
19
20 Are you able to help us at all, even approximately, as 10:32
21 to when in the context of those events - before those
22 events or much after those events - that Mrs. Gishkori
23 spoke to you?
24 A. If I were -- I'm not certain by any means but I think
25 it might have been in and around the September time. 10:33
26 But again, I'm not certain. It would have been, yes,
27 in and around September '16, I think.
28 11 Q. It would appear from what we saw on the last occasion
29 that you had some dealings, perhaps in quantitative

1 terms quite a lot of dealings, with Mrs. Gishkori over
2 that period of time. Is that fair?
3 A. Sorry, I interacted with Mrs. Gishkori?
4 12 Q. In terms of your engagement with Mrs. Gishkori in
5 September 2016. 10:34
6 A. Yes.
7 13 Q. In terms then of what you were told about
8 Mrs. Brownlee's conversation with Mrs. Gishkori, could
9 you help us as precisely as you can in terms of what
10 you were told? 10:34
11 A. I mean, I can't remember exactly but it was something
12 along the lines of Mrs. Gishkori said that she had
13 received a phone call from Mrs. Brownlee, and the
14 content of that conversation was Mrs. Brownlee asking
15 Mrs. Gishkori to - and then these are my words -- go 10:34
16 easy on Mr. O'Brien as he was a good doctor.
17 14 Q. Okay.
18 A. But again, I didn't make a note of that meeting.
19 I didn't register it.
20 15 Q. But is it fair to say is that, if you like, the broad 10:35
21 memory --
22 A. Yes.
23 16 Q. -- with all its frailties that you describe that you
24 take from that conversation?
25 A. Yes. My memory is I was spoken with, Mrs. Gishkori did 10:35
26 tell me, and I think there may have been others. And
27 it was broadly along those line that Mrs. Brownlee had
28 phoned her and asked her to go easy on Mr. O'Brien.
29 But again, those are my words.

1 17 Q. In terms of Mrs. Gishkori's response to that, as she
2 was describing it to you, did it have an impact on her,
3 are you able to say? How did she react to what she had
4 been told in terms of how she was describing it to you?
5 A. Again, I think she was annoyed. Yes, I think she was 10:36
6 annoyed. Maybe upset. I genuinely can't remember her
7 emotions, her reactions. So, I'm guessing she would --
8 well, she would have been upset to have received that
9 phone call.
10 18 Q. Did you form the impression from your memory that you 10:36
11 were being told about this shortly after the phone call
12 happened?
13 A. Yes, I believe so. Yes.
14 19 Q. Was anybody else present when Mrs. Gishkori told you
15 about it? 10:36
16 A. I have no memory of anybody else being present.
17 20 Q. How did you react to it in terms of your thought
18 processes around it?
19 A. Again, I thought it was unusual in that the Chair would
20 ring the Director and instruct her - again, those are 10:37
21 my words - instruct her to go easy with Mr. O'Brien.
22 I've never known it to happen. In my working career,
23 I've never known it to happen.
24 21 Q. Now, Mrs. Corrigan, as I've said, indicates it was you
25 that told her about it. Do you recall that? 10:37
26 A. I genuinely don't, no. I'm sure I did. I've no doubt
27 I did, but when I did it, I have no memory of.
28 22 Q. Moving on. I want to look for the next short while at
29 what happens after you emerge from September.

1
2 If we can put up on the screen TRU-257640. We saw on
3 the last occasion, Mr. Carroll, how, on 22nd September,
4 you had brought your assistance to bear on a letter
5 drafted by Mr. Weir which was to form part of this 10:39
6 alternative approach, alternative to the Oversight
7 Committee, and led, it seems, by Mrs. Gishkori. You
8 clarified that your approach was to try and add
9 robustness in terms of the monitoring ability and the
10 quantification of these issues. 10:39
11
12 Now, there was an Oversight Committee meeting three
13 weeks later then on the 12th October. If you just
14 bring that up on the screen, please. AOB-01079. At
15 the bottom of that page, this is the 12th October - 10:40
16 you're obviously not present at this meeting - the
17 decision made, if we go to the bottom of the page, is
18 that:
19
20 "Mrs. Gishkori has informed the Committee that 10:40
21 Mr. O'Brien is going for planned surgery in November;
22 likely to be off for a considerable period. It was
23 noted that Mr. O'Brien had not been told of the
24 concerns following the previous oversight. It was also
25 noted that a plan was in place to deal with the range 10:40
26 of backlogs within Mr. O'Brien's practice during his
27 absence. Then Mrs. Gishkori gave an assurance that
28 when Mr. O'Brien returned from his period of sick
29 leave, that the administrative practices identified by

1 the Oversight Committee would be formally discussed
2 with him to ensure there was an appropriate change in
3 behaviour. It was agreed that this would be kept under
4 review by the Oversight Committee".
5 10:41
6 I wonder if you can help us with this. Mr. O'Brien
7 doesn't go on sick leave until the middle of November.
8 You had contributed to finalising the letter that was
9 to go to him on 22nd September; roughly a period of
10 three months between those dates. What we see here in 10:41
11 this decision, seemingly led by Mrs. Gishkori, that
12 Mr. O'Brien would not be spoken to until after he came
13 back from his leave of absence, his sick leave. Were
14 you privy to her thinking in that respect or any
15 discussions in relation to that? 10:42
16 A. No. I don't recall Esther and I having any discussion
17 in regard to or leading up to this October Oversight
18 meeting.
19 23 Q. So after contributing to the letters --
20 A. Yes. 10:42
21 24 Q. -- as we've just seen, was that, in essence, your final
22 act or your final input around this?
23 A. Well, as I said the last time I sat here, I viewed this
24 plan to be being controlled by Dr. McAllister and
25 Mr. Weir. I had said if you needed assistance with any 10:42
26 part or all, I was happy to do that. So, I was waiting
27 on either of those senior doctors to come back, or
28 Mrs. Gishkori to come back, but they never came back to
29 me so I never progressed with anything. I don't recall

1 having conversations with Mrs. Gishkori leading up to
2 this meeting.
3 25 Q. In terms of whether there was any awareness of
4 continuing risk to patients, any discussion around
5 that, you simply aren't in a position to assist us? 10:43
6 A. Well, I don't recall any discussions being had with me
7 in regard to progressing Mr. Weir's action plan as of
8 the 22nd. Now, I know Mr. Weir in his evidence said he
9 was looking for the initial meeting with Mr. O'Brien to
10 be with Dr. McAllister and they just found it difficult 10:44
11 to get dates between all three lined up. I suppose
12 that's the only I can offer. But in terms of my input,
13 I didn't do anything other than what I did to
14 Mr. Weir's plan.
15 26 Q. In terms of your input, you are the Assistant Director 10:44
16 with responsibility, obviously with people below you
17 and people above you, for this service. Did you not
18 feel any inclination to push this towards commencing
19 the process with Mr. O'Brien, it having been, if you
20 like, on the agenda in one shape or form, one form or 10:44
21 another for most of 2016?
22 A. I know it's very difficult and hard to explain that for
23 that length of period, no action was taken, but
24 I suppose that's the reality. Again, my take on the
25 meeting that we had with Dr. McAllister and 10:45
26 Mrs. Gishkori on the 14th September was Dr. McAllister
27 and Mrs. Gishkori and Mr. Weir, they had a plan and
28 they would take the plan forward to bring an outcome, a
29 positive outcome, a suitable outcome in terms of the

1 management of Mr. O'Brien. Whilst I contributed to
2 editing in some way the Mr. Weir plan, maybe naïvely
3 I was leaving it to the senior doctors to progress.
4 27 Q. Could I put a perspective to you which goes something
5 like this: Mr. O'Brien is, it appears, plainly in the 10:46
6 dark that all of these events are taking place behind
7 the scenes in respect of him. These matters directly
8 concern him. On the one hand, we have NCAS advising
9 that Mr. O'Brien needs significant support to be able
10 to address these matters, and these matters are allowed 10:46
11 to drift with no action being taken, no discussion with
12 him. Then we get to the Oversight Group meeting on
13 22nd December, taking a decision to have a formal MHPS
14 investigation and exclusion of him - and views may
15 differ about his response to the letter of 23rd March - 10:47
16 but he has not been engaged to do anything about his
17 shortcomings and he has not been provided with any
18 support to address his shortcomings.
19
20 Is he entitled to feel aggrieved about that, in your 10:47
21 view?
22 A. Yes. With hindsight, absolutely. I mean, the whole
23 process of any dispute or any member of staff who is
24 underperforming, or viewed or deemed to be
25 underperforming, is about two-way communication. So 10:48
26 yes, with hindsight Mr. O'Brien should have been spoken
27 with, should have been advised of what was happening;
28 what had happened and what was happening.
29

1 I don't recall me being exposed to NCAS advice leading
2 up to -- and I think I only read it in preparation for
3 the Inquiry. But I take your point, Mr. O'Brien should
4 have been communicated with.
5 28 Q. It may well be, as perhaps is implied by this minute, 10:48
6 and we'll hear from Mrs. Gishkori this afternoon, that
7 a decision was taken, perhaps from a welfare
8 perspective or a soft-landing perspective, if I can put
9 it in those terms, that Mr. O'Brien shouldn't be
10 approached on the edge of going in for a procedure 10:49
11 himself. That's not something you can comment upon, is
12 it?
13 A. No. I just think as a principle of fairness,
14 Mr. O'Brien should have been consulted with.
15 29 Q. Yes. Thank you. 10:49
16
17 Now, we know that when Mr. O'Brien was given the March
18 letter, it provided that he should return patient
19 charts to the hospital premises without further delay.
20 Now, I just want to ask you some questions around what 10:49
21 happens in October and November in relation to that
22 issue.
23
24 If we could have up on the screen, please, TRU-251438.
25 Perhaps just scroll down to the bottom of the page, and 10:50
26 down maybe into the top of the next page and I can pick
27 it up from there.
28
29

1 Pamela Lawson, is she in medical records?
2 A. Yes. She's the head of.
3 30 Q. So 17th October, five days after the last Oversight
4 meeting, she has just learned that Mr. O'Brien is going
5 off on sick leave and she would like to get any charts 10:51
6 back into Records from his home. She notes that
7 Martina Corrigan is off on leave until the end of the
8 month, and she's asking is there anything we could do
9 in the meantime. So, that issue is on her agenda.
10 10:51
11 If we scroll up to the top of the next page.
12 Simon Gibson is asking Martina, upon her return from
13 leave:
14
15 "In the context of discussions held last month, do you 10:51
16 know volume of charts Dr. O'Brien has at home?"
17
18 So, that issue hasn't gone away, some people are
19 actually thinking about it. But perhaps the easiest
20 knot to untangle arising out of the March letter should 10:52
21 have been the "notes at home" issue. We'll see by
22 January of 2017 the number of notes that return from
23 his home.
24
25 Can you help us with this, and maybe you don't agree 10:52
26 that maybe it was the easiest knot to untangle, there
27 doesn't seem to have been any follow-up on even that
28 issue, "please get your notes back into the hospital.
29 You were told in March that we require them back

1 forthwith". Was that an issue that ever crossed your
2 desk?
3 A. I suppose the short answer is no. I didn't progress
4 any aspect of the March '16 letter, as I said on the
5 2nd March. I mean, I'm not being copied into these 10:53
6 emails so that was going on without me knowing. Would
7 it be possible to pull up the March letter?
8 31 Q. Indeed. It's to be found at -- I don't have the
9 reference right to hand.
10 MR. BOYLE: AOB-00979. 10:53
11 MR. WOLFE KC: Thank you, Mr. Boyle.
12 32 Q. That's the letter of 23rd March. If we scroll down to
13 the next page, please. "Patient notes at home".
14 You were going the right way. Thank you. Just pause
15 there. 10:54
16
17 He has been told:
18
19 "This has been an ongoing issue for years and needs
20 addressed urgently. We request that all Trust charts 10:54
21 that are in your Home or in your car be brought to the
22 hospital without further delay".
23
24 I used the word "forthwith" earlier. Does that assist
25 you with what you wanted to say? 10:54
26 A. Again, I'm just restating what I said earlier. I mean,
27 I didn't progress any of the actions 1 to 4 on the
28 March '16. I admit, as I said previously, with
29 hindsight it's something I regret, and I should have.

1 33 Q. There's another development around this that I wish to
2 put to you. If we just bring up on the screen, please,
3 AOB-01226. We have here - just that so I can see the
4 text - Mr. O'Brien is writing to Martina Corrigan on
5 14th November. He says that he's going to be having 10:55
6 his surgery on Thursday morning, expects to be home
7 again over the weekend. He says:
8
9 "I expect that I will be well enough to dictate
10 correspondence concerning patients and have the charts 10:55
11 delivered to Noleen's office", that's his medical
12 secretary, "for typing".
13
14 "I would greatly appreciate if I could be afforded this
15 opportunity to have all charts returned in this 10:56
16 manner".
17
18 So, he is off sick. It's quite clear from the email
19 that he intends to work while on sick leave or while
20 convalescing, and it is quite clear that he has notes 10:56
21 at home.
22
23 If we could just go on up. That's right, that
24 direction. So Martina responds, saying:
25 10:56
26 "I'm more than happy with this plan. Please let me
27 know if there is anything I can do to assist."
28
29 Then she asks about a particular chart which Governance

1 are seeking.
2
3 Again, you're not copied into this but it would appear
4 on any analysis that Mrs. Corrigan is not only aware of
5 the continuation of the charts at home saga, but she is 10:57
6 giving her blessing to a plan which allows him to work
7 at home while on sick leave on those charts and return
8 them in the manner that he sees fit when he's done with
9 the dictation, it seems. Again, is that issue
10 something that you were consulted upon? 10:57
11 A. Again, the short answer is no. I only became aware of
12 this email in the bundle. Martina and I -- I have no
13 recollection of Martina and I discussing Mr. O'Brien
14 working whilst on sick leave to catch up on his
15 dictation. 10:58
16 34 Q. In light of what we know was the Trust's purported
17 concern to get these charts back, and you have a
18 situation where one of your managerial colleagues is
19 seemingly, and for reasons we can explore with her,
20 endorsing a continuation of the status quo ante, how 10:58
21 does that sit with you?
22 A. Well again, it undermines the principle or the purpose
23 of the March 2016 letter, in that the Trust felt it
24 appropriate to formally write to Mr. O'Brien asking
25 them to action the four elements of what was documented 10:58
26 in the letter and for him to come back with a plan. In
27 fact, Martina was a part author of that letter to
28 Mr. O'Brien. I suppose what I would say to the Inquiry
29 is that it undermined that letter and the purpose of

1 that letter.
2 35 Q. The fact that the letter had been issued... Just to
3 focus on this issue of the notes - nobody had rapped
4 his door again to say, 'March letter. You were told in
5 clear terms, get these notes back'. The fact that that 10:59
6 doesn't happen and then we have this, Mrs. Corrigan
7 endorsing retention of the notes for the purposes of
8 allowing him to dictate, it reflects an inconsistent
9 practice at best?
10 A. I wouldn't disagree with you on that. It doesn't read 11:00
11 very well.
12 36 Q. So October, we're into November. Is it the case, in
13 terms of your role, because of the decision taken at
14 the Oversight meeting in October to await Mr. O'Brien's
15 return before this issue is going to be grappled with, 11:00
16 that you're getting on with your many other tasks, and
17 Mr. O'Brien's world and the concerns that the Trust had
18 about him are not on your agenda any more until
19 December?
20 A. That would be fair to say, yes. 11:00
21 37 Q. An email is written on the 6th December. Just pull
22 this up on the screen. TRU-251827. We can see
23 Esther Gishkori is writing to Dr. Wright, then Medical
24 Director, copying Vivienne Toal. She is updating him
25 that Mr. O'Brien has had surgery, and sick lines are 11:01
26 being submitted. If we scroll down, she's referring
27 here to the "SAI review continuing and will no doubt
28 produce its own recommendations", and I want to turn to
29 that SAI from your perspective in a moment. That's the

1 SAI concerning Patient 10. You know who I'm talking
2 about.
3
4 She said in the concluding paragraph:
5 11:02
6 "I have been having conversations in relation to
7 Mr. O'Brien's 'return to work' interview. We thought
8 this would be a good time to set out the ground rules
9 from the start. Since Colin and Charlie are both off
10 sick, Mark wondered if you and I could do this. Since 11:02
11 there are both professional and operational issues
12 here, I feel that this is entirely reasonable."
13
14 So, this is the 6th December. Up the page, please.
15 Richard Wright signals that this sounds very reasonable 11:02
16 and asks "any ideas when that is likely to be?"
17
18 In terms of your engagement, this is the 6th December,
19 do you have any understanding that this is how it is to
20 be done, Mr. O'Brien would be spoken to after he 11:03
21 returned? I suppose it is only reinforcing to some
22 extent what had been decided in October.
23 A. Yes. That's what I was going to say, it sounds like a
24 follow-on from what Mrs. Gishkori fed back to the
25 Oversight Committee in October. Again, I'm not in 11:03
26 those emails and I don't recall having discussions with
27 Mrs. Gishkori about what she wrote to Dr. Wright.
28 38 Q. There's no sense at this stage, while the SAI is
29 mentioned and there's an awareness that there is an SAI

1 working its way through the system, there's no
2 suggestion at this stage that the SAI is going to
3 affect the plan or the strategy going forward with
4 regard to Mr. O'Brien?
5 A. The strategy in terms of Mr. Weir's... 11:04
6 39 Q. In terms of how Mr. O'Brien's shortcomings or perceived
7 shortcomings would be managed?
8 A. No. I don't recall being party to any conversation in
9 regard to -- I suppose from my mind, Mr. Weir's plan
10 was still the plan that was on the table to be 11:04
11 progressed.
12 40 Q. Yes.
13 A. Now, I do appreciate Dr. McAllister in October, and
14 then Mr. Weir, both went off on sick leave, and maybe
15 with hindsight that was a missed opportunity to sit 11:04
16 down and have a discussion about Mr. Weir's plan and
17 the possibility or the reality would it ever be --
18 would life be given to it, and should we have a rethink
19 and revisit the decision of the September Oversight
20 Committee meeting. But that never -- and that's just 11:05
21 me with hindsight. But those discussions never took
22 place.
23 41 Q. Now, the sense that this could be left until after
24 Mr. O'Brien returned to work and the rules would be set
25 out to him at a return-to-work meeting, the strategy, 11:05
26 if you like, or that plan going forward was to change
27 upon developments around the SAI. Do you recall that?
28 A. Yes. I think, from reading the evidence, Mrs. Gishkori
29 received communication from Dr. Boyce in November,

1 I think the middle of November, where she gave
2 I suppose a heads-up as to what the SAI Panel chaired
3 by Mr. Glackin was saying. Then I think Mrs. Gishkori
4 writes a separate email to Mr. Wright in regard to her
5 concerns about the SAI. 11:06
6 42 Q. Yes. I can help you with that by putting up some of
7 the documents. Maybe if we just help the Inquiry
8 through this if we look just briefly at what you said
9 in your statement on this, WIT-21122. At 14.1, you
10 say: 11:06
11
12 "On 16th December I received an email from Dr. Tracey
13 Boyce of Pharmacy with responsibility to Acute
14 Governance, addressed to Mrs. Gishkori. The email had
15 attached to it a letter of 15th December 2016 from 11:07
16 Mr. Glackin expressing three concerns vis the default
17 triage system, the patients' notes leaving the Trust
18 and patients' letters not being dictated in a timely
19 manner".
20 11:07
21 Then you go on to talk about the Oversight Committee
22 meeting which was to meet within the week.
23
24 Let's just go then to what Dr. Boyce sent to you. It's
25 a letter or a note marked "Dear Tracey". If we could 11:07
26 have that up on the screen, please. It's AOB-01245.
27
28 While this isn't signed, it's your understanding that
29 it's authored by Mr. Glackin, who was leading on the

1 SAI review for Patient 10; is that right?
2 A. That would be my assumption, yes.
3 43 Q. He's setting out in this document, is it fair to say,
4 some findings and analysis and concerns arising out of
5 the SAI review? 11:08
6 A. Correct.
7 44 Q. If we just scroll down the page, please. Further on
8 down, thank you. Just back down, please, to the bottom
9 of the page.
10 11:09
11 He's saying that upon conclusion, the Review Team have
12 a number of concerns in relation to Mr. O'Brien's
13 practice, it seems, which go beyond the instant case,
14 that go beyond simply Patient 10's case. Is that your
15 understanding? 11:09
16 A. Yes. Yes.
17 45 Q. If we scroll down further, please. He says that "these
18 issues and themes concern the following", and he sets
19 out three issues.
20 11:10
21 The first issue is the use of an informal process to
22 monitor and manage urology letters which had not been
23 returned with management advice, in other words they
24 hadn't been triaged. That's the first issue.
25 11:10
26 The second issue is that a look-back exercise had been
27 conducted and it revealed that a patient chart could
28 not be found on the premises. Just scroll down,
29 please. He says:

1
2 "On balance the Review Team agree there is sufficient
3 cause for concern that Trust documentation may be
4 leaving Trust facilities and the process of record
5 transportation for this speciality does need urgently 11:11
6 addressed".
7
8 Then, thirdly, the review Panel say that they have
9 grave concerns, the third sentence:
10 11:11
11 "That other urology patient letters are not being
12 dictated in a timely manner". They say that:
13
14 "The Panel have found that the Trust does monitor the
15 number of charts needing audio-typing of dictation but 11:11
16 there does not appear to be a robust process to monitor
17 if post-consultation patient dictation has been
18 completed".
19
20 That's a summary of what that "Dear Tracey" letter 11:12
21 concerns.
22
23 In terms of your response to it, the SAI itself,
24 Patient 10's SAI, when did you first become aware of
25 that? 11:12
26 A. I think probably in and around this time. When I
27 received this letter via Dr. Boyce, I remember speaking
28 to Mrs. Corrigan and tried to dissect what Mr. Glackin
29 was referring to see if we could understand and could

1 we quantify some of the issues. So probably in and
2 around this time of Patient 10's SAI.
3 46 Q. We can see - and I don't need to bring it up on this
4 screen, the reference for the Panel is PAT-000053 -
5 that an SAI in respect of Patient 10 was notified in 11:13
6 March 2016, and that was consequent upon an incident
7 report having been raised by Mr. Haynes in January of
8 that year. So, it's notified in March 2016 and it's
9 reporting, as we can see from the "Dear Tracey" letter,
10 towards the end of the year Dr. Glackin is saying 11:14
11 we completed the SAI. Is it right to say that you have
12 no awareness of it trundling through the system until
13 that time?
14 A. Yes. I would not have been aware of, obviously in
15 March of -- sorry, in January 2016, the Datix being 11:14
16 completed. I know Mrs. Gishkori in her evidence does
17 reference speaking to me and Mrs. Trouton in regard to
18 it. In terms of Patient 10 registering with me and the
19 gravity of it was probably when I received the "Dear
20 Tracey" letter. 11:15
21 47 Q. Does that suggest in governance terms, an SAI being
22 worked through the system isn't the subject of
23 discussion in any forum in 2016 that you were a member
24 of?
25 A. No. The normal process for any SAI would be the Datix, 11:15
26 the screening, the investigation, and then the
27 reporting at the end of investigation. That would have
28 come to the Acute Governance meeting which was held on
29 a monthly basis. It would not have been common

1 practice that an SAI would be referred to before the
2 report had concluded, unless there was something
3 extremely grave in it.
4 48 Q. This is a slight tangent to what we're talking about,
5 but has that situation changed now? Is there a better 11:16
6 ability in terms of the service that owns the SAI or is
7 most interested in the SAI to keep tabs on it?
8 A. So, yes. We would have monthly governance meetings at
9 which would be the governance coordinators, and they
10 would update us as to progress or not of SAIs. That 11:16
11 would be a normal practice now.
12 49 Q. As we can see from the "Dear Tracy" letter, it refers
13 in the first bullet point to this method for dealing
14 with triage that hasn't been done. It's referred to as
15 an informal process for managing urology letters not 11:17
16 triaged.
17
18 Can I ask you about something you've said about that to
19 Dr. Chada. TRU-00763. Maybe bring it back up so the
20 witness can see. At paragraph 8, you're referring us 11:17
21 to the issues raised by Mr. Glackin. You say at
22 paragraph 9:
23
24 "It came to my attention through this that because
25 referrals from the booking centre were not coming back 11:18
26 from Mr. O'Brien's office, it had been agreed that if
27 referrals didn't come back, the secretary would put
28 them onto the system according to the GP triage so they
29 would not be lost in the system. Mr. Glackin wrote

1 expressing concern about that".
2
3 You say "I believe it may have been November '15" but
4 you can see it is November 2016.
5 11:18
6 Is it the case that it's only when Mr. Glackin wrote
7 the "Dear Tracey" letter, that it came to your
8 attention that this default arrangement, if I can call
9 it that, for the processing of untriaged referrals
10 comes to your attention? 11:19
11 A. Yes. Yes. I mean, I don't recall having an
12 understanding prior to that that the default system was
13 in operation. I suppose my understanding is the
14 default system came into operation in around 2014, and
15 I would not have been aware of it in my previous 11:19
16 Assistant Director role. So when I came in in April,
17 I don't recall Mrs. Trouton or Mrs. Corrigan advising
18 me of the default system. Unless they're going to say
19 something different, but that's my recollection,
20 I didn't become aware of it until Mr. Glackin made 11:20
21 reference to it.
22 50 Q. You're obviously the Assistant Director within Acute.
23 I know urology and the business around Mr. O'Brien is
24 not the only item on your desk, and your involvement in
25 that sort of peaked and troughed depending upon when 11:20
26 the issues came up. We saw on the last occasion you
27 were in receipt of the March letter. If we just bring
28 that up again, it is at TRU-274696. If we can look
29 just under triage.

1
2 "There are currently 253 untriaged letters". It goes
3 on to say: "Lack of triage means we do not know
4 whether the patients are red-flag, urgent or routine.
5 Failure to return the referrals to the Booking Centre 11:21
6 means that the patients are only allocated on a
7 chronological basis with no regard to urgency".
8
9 That is an indirect description of the default system,
10 isn't it, that when triage isn't done, the system kicks 11:21
11 in to allocate on the basis of chronology rather than
12 any assessment of clinical urgency?
13 A. Yes. I mean, I accept that point. The patients were
14 kept on whatever the GP had clinically prioritised them
15 at. 11:21
16 51 Q. Is that something you didn't know? What did you think
17 happened to referrals that weren't triaged?
18 A. I mean, in terms of registering with me, as I said,
19 this letter I didn't act on in regard to when it
20 reached my consciousness in terms of needing acted was 11:22
21 around Mr. Glackin's "Dear Tracey" letter. I think
22 you're being very fair in terms of I mean urology, and
23 Mr. O'Brien particularly, was a very small element of
24 my day-to-day work with many other challenges which
25 would come across my desk on a daily basis. So yes, 11:22
26 I accept reading that in the cold light of day it does
27 make reference to the default system.
28 52 Q. But is it the case - and help me if you can with this -
29 that for whatever reason, whether inattention to

1 detail, whether it's just the complexities of your
2 working life, that you didn't fully appreciate,
3 you didn't have a sensitivity to the implications of
4 what you knew was going on with Mr. O'Brien's practice
5 in terms of his failure to triage? 11:23
6 A. I think that's fair.
7 53 Q. If we go back to the "Dear Tracey" letter, AOB-01246.
8 If we go to the top bullet point. Mr. Glackin records,
9 about a quarter of the way down:
10 11:24
11 "The presence of this process implies that it was
12 accepted that triage noncompliance was to be expected
13 by a minority of consultants within the urology
14 specialty. On 6 November 2015, an email from the AD of
15 Functional Service formally implementing this process. 11:24
16 The Review Panel are anxious that the current process
17 does not have a clear escalation plan which evidences
18 inclusion of the consultant involved. In addition,
19 this process has not been effective in addressing
20 triage noncompliance. From 28th July 2015 until 11:25
21 5th October 2016, there are 318 patient letters which
22 are not triaged".
23
24 I suppose that sets the problem with it in context.
25 The failure to triage was not actually being grappled 11:25
26 with and there was no way of dealing with it, or the
27 system seems to have given up on dealing with it. Is
28 that a fair way to look at it?
29 A. I think I have reflected on this in my statement.

1 I think I said it was a flawed system. The default
2 system was flawed for the reasons Mr. Glackin has just
3 provided. It didn't address the underlying issue of
4 non-triage or delayed triage.
5 54 Q. We'll go on and see in a moment that it appears to be, 11:26
6 at least in part, the arrival on your doorstep of this
7 letter and the implications of the failure to triage
8 for a particular patient that was to be a trigger for
9 the MHPS investigation. We'll look at that. This
10 sense that failing to triage could place patients at 11:26
11 risk, that would have been as obvious in -- it should
12 have been as obvious in September, shouldn't it, as it
13 appears to have become obvious in December?
14 A. I accept your point. I would also say it should have
15 been as obvious when it was initiated in 2014 or '15, 11:27
16 that the implementation of the default work-around did
17 not fix the problem.
18 55 Q. Yes, I think that follows. I appreciate you for saying
19 that.
20 11:27
21 In your statement you recall meeting with Mrs. Corrigan
22 after receiving this "Dear Tracey" letter. I think you
23 suggest that you received the "Dear Tracey" letter on
24 16th December but, in fact, we see action from
25 Mrs. Corrigan on 15th December. So, it may well be 11:27
26 that you received the "Dear Tracey" letter on the 15th.
27 A. Yes.
28 56 Q. Leaving that fine detail to one side, you say
29 Mrs. Corrigan was asked to go away, as such, and report

1 on the various issues that arose from the "Dear Tracey"
2 letter?
3 A. Yes.
4 57 Q. We can see, for example if we go to WIT-14348, that in
5 respect of triage, these details are passed on to you 11:28
6 on 22nd December. But if we just scroll down the page,
7 please. Christine Rankin on 15th December is writing
8 to Connie Connolly and Katherine Robinson. She is
9 saying:
10 11:29
11 "As discussed please find attached spreadsheet
12 containing 318 records which never came back from
13 strategic".
14
15 It says: 11:29
16
17 "Copies of the letter for those highlighted in yellow
18 have since been looked at by Mr. Brown and he has
19 agreed the conditions are something he can see as
20 opposed to whether or not the referral should be urgent 11:30
21 or routine. We are currently booking these to
22 Mr. Brown's clinics," etcetera.
23
24 Do you know whether that activity -- it was directed by
25 Mr. Glackin; we can see that figure of 318 in his 11:30
26 report. Was any other work done around triage at that
27 time in terms of interrogating the issues, from your
28 perspective?
29 A. No. Not at that stage, no. No.

1 58 Q. I suppose what stands out clearly from this email is
2 that the Trust, through its staff, were clearly able to
3 understand the extent to which triage wasn't being
4 performed, isn't that right? The system enabled them
5 to keep a track of this and produce the numbers. 11:31
6 A. Yes.
7 59 Q. This issue wasn't hidden?
8 A. I think what I could say or what I would offer is that
9 with the default system in place, I suppose there was a
10 false sense of security. I don't recall escalating 11:31
11 emails from the booking centre in regard to, for
12 example these 218 records. Maybe everybody felt with
13 the default system - and it had been in place since
14 2014 or '15 - that things were continuing on as had
15 been for several years. 11:32
16 60 Q. Yes. What the Inquiry has seen is that up until
17 introduction of the default system, there was a regular
18 informal escalation process. So, emails would reach
19 Mrs. Corrigan and she would then chase Mr. O'Brien to
20 get the triage back. With the introduction of the 11:32
21 default system, that escalation process didn't occur.
22 The cases, if they were left untriaged, simply went on
23 the waiting list in accordance with the referrer's
24 clarification?
25 A. Yes. 11:32
26 61 Q. Again, another flaw of the system; isn't that right?
27 A. As I said in my statement, I think the system was
28 flawed.
29 62 Q. As regards undictated clinics, this "Dear Tracey"

1 letter seemed to have spurred some work around that.
2 If we go to TRU-255968. Just scroll down the page,
3 please.
4
5 Noleen Elliott on 15th December is e-mailing Andrea 11:33
6 Cunningham. The subject is Backlog Report - No Clinic
7 Outcomes. She says:
8
9 "Please find attached list of clinics with no outcomes
10 completed as per 15th December...". 11:34
11
12 If we go back up the page, please. Keep going, thank
13 you. Keep going. Katherine Robinson writes to Anita
14 Carroll on this subject, and she says:
15 11:34
16 "See the attached list. This is a list of clinics that
17 Mr. O'Brien has not dictated on and hence no outcome
18 for some of these patients. There is a risk that
19 something could be missed so I am escalating to you,
20 although I know that a lot of the time Mr. O'Brien 11:35
21 knows himself what is to happen with patients.
22 Unfortunately, this was not highlighted on the backlog
23 report. The secretary assumed we knew because there
24 have always been issues with this particular
25 consultant's administrative work from our perspective. 11:35
26
27 "As learning from this discovery, I have asked all
28 secretaries to provide this information on the backlog
29 report so that we fully understand the whole picture of

1 what is outstanding in each specialty. The secretary
2 also advises that at present Mr. O'Brien is working on
3 some of his backlog admin work as he is off sick
4 recovering."
5 11:35
6 Just go on up the page, please. This is copied to you
7 on the day of the Oversight meeting, which we'll come
8 to in a moment. You then forward it on the day after
9 the meeting, albeit I think it was the subject of
10 discussion at the meeting. 11:36
11
12 Just go up the page again, please. Allow me a moment,
13 Chair. If we could scroll down to TRU-255969. What we
14 have here and on the subsequent page, 70 in this
15 sequence, is 61 clinics which are said by Mrs. Elliott 11:36
16 not to have been completed in terms of dictation. This
17 is the origin of the 61 clinics which was to feature in
18 Dr. Chada's report.
19
20 What was your understanding of the backlog report, 11:37
21 Mr. Carroll? Was that something that you had a working
22 appreciation of?
23 A. It was a report that I only came exposed to when
24 I became Assistant Director for Surgery; it wasn't a
25 report that was previously in the cancer and clinical 11:37
26 services. My understanding was it was the backlog
27 report described several aspects of the secretarial
28 staff work. For example, ward discharges. I think
29 there was two elements which referred to patients on

1 the ward, and then the third column referred to
2 dictation, outpatient dictation. So clinics and the
3 number of letters which were waiting to be dictated and
4 typed.
5 11:38
6 My understanding, the development of that report was
7 for the secretary, the RBC, to have an understanding of
8 the working volume across all the secretarial staff to
9 see was everybody up to date with their typing and, if
10 they weren't, could resources be reallocated across the 11:38
11 secretarial team. That's my understanding of the
12 origins of the report.
13 63 Q. So, it was essentially a way of allowing managers to
14 understand whether there was a typing backlog in any
15 part of the system and, if so, whether it could be 11:39
16 reallocated to any spare capacity amongst the typing
17 pool?
18 A. Yes.
19 64 Q. The criticism which Katherine Robinson seems to
20 suggest, if we go back to 67 in that series, two pages 11:39
21 up, is that Mr. O'Brien's secretary was not
22 highlighting on the report that dictation was not being
23 completed. Was that the expectation of the secretary
24 or, indeed, of the backlog report?
25 A. From my perspective, I mean the role of the 11:40
26 consultant's secretary is to clearly undertake the
27 typing associated with the work of the consultant in
28 its totality, whether it be in-patient or outpatient
29 activity. My expectation would be that any secretary

1 would be dictating the outcomes of clinics as they
2 received them from their consultant.
3 65 Q. Of course. The point, I suppose, I'm asking is if
4 Mr. O'Brien sees 12 patients at a clinic at the SWAH on
5 a Wednesday afternoon but only two or three letters are 11:40
6 dictated and come back to his secretary, what is she to
7 do with her knowledge that he hasn't dictated on the
8 remainder?
9 A. So, my expectation is that she would speak to
10 Mr. O'Brien and say the clinic in SWAH, of the twelve 11:41
11 patients seen, you've only dictated on three, where are
12 the other nine? Then there would be an outcome from
13 that. If there was no outcome, then I would expect her
14 to have escalated that to her services administrator.
15 66 Q. If he's telling her, for example, I don't need to 11:41
16 dictate on those now, they're not urgent or whatever,
17 there's no expectation that she should take that
18 anywhere else; her relationship is with Mr. O'Brien?
19 A. Well, yes, and I don't underestimate the relationship
20 between the consultant and the secretary but also she 11:42
21 has a responsibility to escalate to her superior, not
22 least because if she's not dictating Mr. O'Brien's
23 work, what is she doing.
24 67 Q. The point being she is dictating his work, he's not
25 necessarily dictating on all of the clinical entries. 11:42
26 She can't dictate if there's nothing to dictate.
27 A. What I'm trying to say, in your example if there's 12
28 patients and he only gives his secretary three, as
29 opposed to 12, she is only doing a quarter of the work

1 that she should be typing.
2 68 Q. How is his failure to dictate, if we can call it that -
3 and I know that that's not uncontroversial from his
4 perspective - but how is that failure to dictate on a
5 clinical encounter to be reflected on a backlog report? 11:43
6 A. It's not. I mean, I think that's one of the flaws in
7 the system also. The report is only as good as the
8 data that feeds it. If Mr. O'Brien is not dictating
9 and there's a zero against Mr. O'Brien in the dictation
10 column, you're lulled into a false sense - as we were - 11:43
11 you're lulled into a false sense that Mr. O'Brien is up
12 to date with his dictation.
13 69 Q. We know from the March letter that the system was
14 aware, through his clinical colleagues, his consultant
15 colleagues, that he wasn't up to date with his 11:43
16 dictation. Obviously another source potentially for
17 that might be the medical secretary, and we've looked
18 at that.
19
20 Can I ask you to look at this document. It has been 11:44
21 drawn to our attention by Mrs. Elliott and we'll
22 explore it more fully with her when she gives evidence.
23 It is WIT-76603. I understand that she would describe
24 this - and I shouldn't pre-empt her evidence too much -
25 but this is a document which I understand is sent from 11:44
26 the Data Quality Team to medical secretary managers.
27 Although we don't have any legends at the top to help
28 us understand what the document is, if we can see, for
29 example, when we first reach Mr. O'Brien about six

1 entries down and read across to the fifth column,
2 there's a code, AAOBU1. That relates to an Armagh
3 clinic. The clinic dates from 2nd November 2015. We
4 understand that this report was run in April 2016.
5 This is a method by which the Data Quality Team and the 11:45
6 medical secretary managers, as we understand it - and
7 we can check this with Mrs. Elliott in evidence - it
8 allows them to see where outcomes have not been
9 finalised following a clinic. The shortcoming, for
10 whatever reason, is that it doesn't deal with the SWAH 11:46
11 clinics, and again we can explore that.
12
13 Do you have any knowledge with this kind of report?
14 A. No, I don't.
15 70 Q. That's not something that ever crossed your desk from a 11:46
16 management perspective?
17 A. No.
18 71 Q. In terms then of the system that was in place or ought
19 to have been in place to enable managers to understand
20 whether dictation was happening, were you wholly 11:46
21 dependent, from your experience, on clinical colleagues
22 identifying problems or medical secretaries identifying
23 problems?
24 A. Yes, I think that would be fair to say. And, for what
25 it was worth, the backlog report. 11:47
26 72 Q. The backlog report would tell you about --
27 A. Outstanding dictation.
28 73 Q. Well, it wouldn't tell you outstanding dictation, would
29 it? It would tell you about the level of activity; it

1 would maybe tell you where dictation has yet to be
2 typed, but it wouldn't tell you that Mr. O'Brien or any
3 other clinician has failed to dictate?
4 A. No, and that's what I'm trying to say, is that the
5 report had inherent weaknesses in it. If Mr. O'Brien 11:48
6 doesn't dictate, you're not going to know that in the
7 backlog report. So, yes, there's a shortcoming.
8 74 Q. Is that a shortcoming that remains to this day, or how
9 do health service systems grapple with the possibility
10 that a clinician isn't doing all the work in terms of 11:48
11 dictation that is expected of him?
12 A. Yes. I do think that concern still remains in the
13 health service. I'm not the most up to date in
14 administrative dictation so I may not be the best
15 person to give an opinion, but my understanding is 11:49
16 we did move from audio typists to digital dictation,
17 which improved, but we haven't gone beyond that,
18 I don't believe. I know they tried to bring in another
19 system; I can't recall the name of it. But I think
20 digital dictation is as far as we got. I could be 11:49
21 incorrect in that but someone more authoritative than
22 me could tell you.
23 MR. WOLFE KC: Before we move to the Oversight meeting,
24 can we take a short break, perhaps?
25 CHAIR: Yes. Five past 12, ladies and gentlemen. 11:49
26
27 THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:
28
29 CHAIR: Everyone. Mr. Wolfe.

1 75 Q. MR. WOLFE KC: Mr. Carroll, we've looked at various
2 information coming into the system on triage, on
3 dictation, in the days leading up to a decision to have
4 a meeting of the Oversight group. What is your sense
5 of the mood in those days following the "Dear Tracey" 12:08
6 letter? Were you privy to conversations saying this is
7 a development that needs to be grasped and that the
8 intended track or the intended plan needs to change?
9 A. I have no recollection of being privy to any of those
10 types of conversations. I have seen emails between 12:08
11 Dr. Wright and Mrs. Gishkori in regard to Patient 10's
12 SAI, and then Dr. --
13 76 Q. Let me just bring one of the -- well, the email I'm
14 aware of, up on to the screen. AOB-41585.
15 CHAIR: Mr. Wolfe, might that be 01585? 12:09
16 MR. WOLFE KC: Sorry, WIT-41585. My apologies. Bottom
17 of the page, please.
18
19 Richard Wright is writing to Simon Gibson. Esther has
20 rang, telephoned, Dr. Wright regarding worrying 12:10
21 developments in relation to what is described here as
22 "AOB and lost notes". Do you understand that in the
23 context in which you were working?
24 A. No, I don't.
25 77 Q. In any event, let's read on: 12:10
26
27 "Ronan is to report tomorrow with preliminary
28 findings".
29

1 We know and we'll see at the Oversight meeting that you
2 provided information around triaged dictation and notes
3 at home. Is that what that refers to?
4 A. Possibly, yes.
5 78 Q. He says. 12:11
6
7 "I will come in tomorrow. If you're about could we set
8 up a meeting with Ronan and if possible Mark Haynes to
9 consider findings (Esther is off)".
10 12:11
11 She had some planned leave. It was coming up to
12 Christmas; is that right?
13 A. I know she couldn't make it. Why she couldn't make
14 it, I can't recall.
15 79 Q. He goes on to say: 12:11
16
17 "I don't think we can wait for the formal completion of
18 SAI".
19
20 That's presumably a reference to Patient 10. 12:11
21
22 You were deputed to go to this meeting in place of
23 Esther?
24 A. Correct.
25 80 Q. Do you recall any conversations with her - she was, 12:11
26 after all, the Director of Acute - being, obviously, an
27 important feature of September's interactions of the
28 Oversight Committee and what followed. Any
29 conversation with her as to how you were to represent

1 the views of the directorate at this Oversight meeting?
2 A. No, I don't recall having a conversation with Esther in
3 terms of my attendance at the meeting or her giving me
4 a brief as to a purpose of the meeting. No, I don't.
5 81 Q. We know that - and we don't need to go to these, the 12:12
6 reference is AOB-01393 - Tracey Boyce sends through for
7 the meeting a final draft of the SAI, a summary of the
8 "Dear Tracey" letter, and a spreadsheet relating to
9 triage. Then if we go to the meeting itself,
10 AOB-01280. Just scrolling down to see how the context 12:13
11 is described. It refers to the 13th September meeting
12 where a range of concerns had been identified. It
13 says:
14
15 "A formal investigation was recommended, and advice 12:13
16 sought and received from NCAS".
17
18 Thinking back to that time - I know you weren't a
19 member of the Oversight - did you understand that there
20 was to be a formal investigation or was it to be an 12:14
21 informal approach?
22 A. Reading the evidence bundles, my understanding was the
23 September meeting was meant to be informal. I think
24 Mr. Gibson's letter was 'and if things didn't improve,
25 it would be formal'. 12:14
26 82 Q. It goes on to say then:
27
28 "It was subsequently identified" - as we've seen, we
29 have looked at this this morning - "that a different

1 approached was to be taken as reported to the Oversight
2 Committee on 12 October". **Then:** "Dr. O'Brien was
3 scheduled to return to work on the 2nd January
4 following a period of sick leave, but an ongoing SAI
5 has identified further issues of concern". 12:14
6
7 Is that your understanding, Mr. Carroll, that it was
8 the advent of the SAI and the conclusions associated
9 with it that was the trigger for this meeting?
10 A. Yes, that's what I believe. 12:15
11 83 Q. Where do you obtain that belief from?
12 A. From the email that -- the "Dear Tracey" email which
13 was sent to Esther and I, and then the conversations
14 that were had between Mrs. Gishkori and Dr. Wright.
15 84 Q. We know, I've referred you to it, that there appeared 12:15
16 to be a contentment or an agreement between Gishkori
17 and Wright that these issues could be left until after
18 Mr. O'Brien returned from sick leave. We saw the email
19 earlier to that effect. What was your sense in
20 association with the SAI of what had changed to trigger 12:16
21 this matter being brought forward?
22 A. I think probably - and I could be wrong here, I could
23 be wrong, could be incorrect - this was the first time
24 there was a tangible evidence to senior managers that
25 as a result of the review, that a patient, Patient 10, 12:16
26 had come to harm.
27 85 Q. If we just scroll down slowly through this. Issue 1,
28 this is Tracy Boyce, Dr. Boyce, summarising the SAI.
29 He says:

1
2 "Part of this SAI also identified an additional patient
3 who may also have had an unnecessary delay in their
4 treatment for the same reason".
5 12:17
6 "It is notes as part of this investigation that
7 Dr. O'Brien had been undertaking dictation whilst he
8 was on sick leave."
9
10 Then you report. You report that the triage count was 12:17
11 318 letters not triaged. We've seen earlier how that
12 figure came to light. Sixty-eight were classified as
13 urgent at that point. Do you know how that
14 classification was arrived at?
15 A. More than likely I got it from Mrs. Corrigan. 12:17
16 86 Q. Do you know whether a clinician or someone else had
17 made an assessment of urgency?
18 A. No, I don't.
19 87 Q. You have an action then arising out of that. What was
20 required was a written action plan to address the issue 12:18
21 of triage, isn't that right? We'll look in a moment at
22 how you engaged with clinicians around this.
23
24 If we go to the top of the next page, please. The
25 second issue is described as notes tracked to 12:18
26 Dr. O'Brien, and it is said that a proportion of these
27 may be at his home address. Is it fair to say that at
28 this point, no work had been done to establish just how
29 many charts might be in his possession?

1 A. That's correct.
2 88 Q. It is said that there is a concern that the clinical
3 management plan for these patients is unclear or may be
4 delayed. The action for you, again, is that tracking
5 needs to be undertaken to quantity the volume of notes 12:19
6 tracked to Dr. O'Brien, Mr. O'Brien, and whether these
7 are located in his office.
8
9 Then issue 3. You, again, reporting that there was a
10 backlog of over 60 undictated clinics going back over 12:19
11 18 months. Again, we saw earlier the figure was 61
12 based on what Noleen Elliott had sent through. You
13 have said approximately 600 patients may not have had
14 their clinic outcomes dictated so the Trust is unclear
15 what the clinical management plan is for these 12:19
16 patients. Again, an action for you, with Colin Weir,
17 is to address this issue with a clear timeline.
18
19 Scrolling down. A further action was for Tracy Boyce
20 to consider any previous IR1s and complaints to 12:20
21 identify whether there were any historical concerns
22 raised.
23
24 Just on that one, we'll come to the others separately,
25 do you know whether work around that was ever 12:20
26 performed?
27 A. The fourth action?
28 89 Q. Yes.
29 A. No, I've never seen any. I have never seen.

1 90 Q. Do you agree that in terms of trying to scope an MHPS
2 investigation, consideration of that kind of material
3 might be relevant?
4 A. Yes, on the basis that MHPS is about performance, and
5 part of performance in its totality can be IR1s and 12:21
6 complaints against the practitioner.
7 91 Q. We then come to the consideration of the Oversight
8 Committee and essentially its decision. Just scroll
9 down so we see all of that text. Thank you.
10 12:21
11 In summary, three broad decisions are reached.
12 Mr. O'Brien is to be the subject of exclusion for the
13 duration of a formal investigation. Secondly, there is
14 to be a formal investigation under an NCAS approach,
15 albeit it is recorded that Dr. Wright is to make 12:21
16 contact with NCAS to seek confirmation of this
17 approach. The third broad decision is the appointment
18 of the case investigator, Mr. Weir, and a case manager,
19 Dr. Khan.
20 12:22
21 I just want to ask you, Mr. Carroll, can you help us
22 with this. Obviously, we have a very slimline minute
23 here. Is it your recollection that the direction of
24 travel throughout this meeting was always towards
25 exclusion and a formal investigation; that that was the 12:22
26 intended conclusion made obvious from the start of the
27 meeting?
28 A. My memory of the meeting was when everything was
29 discussed in terms of the data that was presented,

1 there was a feeling that the gravity of everything was
2 more appreciated, and that, in order to understand it
3 more comprehensively to enable operational managers
4 like myself to determine the extent of it, that it
5 might be best if Mr. O'Brien was excluded. That's my 12:23
6 understanding of the meeting.
7 92 Q. In termination of options, because presumably there
8 didn't have to be an exclusion, there didn't have to be
9 a formal investigation, do you have a memory of
10 options, alternatives, being discussed out loud by 12:24
11 anyone at the meeting?
12 A. No, I do not have a recollection of that, no.
13 93 Q. Was it Dr. Wright who suggested exclusion and a formal
14 investigation?
15 A. Yes, would be my... Yes. But am I absolutely sure 12:24
16 that he said those words; no. But I suppose that it
17 would be Dr. Wright who would have suggested it. He
18 was the most experienced in the MHPS process.
19 94 Q. Can you remember options other than exclusion being
20 talked through? 12:24
21 A. I don't, sorry.
22 95 Q. We've seen your role in the meeting up to this point.
23 You're reporting on the facts as, I suppose, the
24 preliminary investigations revealed to you. When it
25 came to this point of the meeting when decisions had to 12:25
26 be made on the way forward, were you a contributor to
27 that part of the decision? In other words, were you
28 part of the decision?
29 A. I would -- as I said when we first met, my knowledge of

1 MHPS, I had received no training, my knowledge was
2 extremely limited in terms of the entire process. From
3 my memory of this meeting, I think most of the
4 discussion was between Dr. Wright and Mrs. Toal. I'm
5 sure I contributed in a small way, but I suppose 12:25
6 I didn't have the knowledge or experience to give any
7 meaningful input would be my view.
8 96 Q. Go ahead.
9 A. But ultimately, maybe you'll come to it, when the
10 decision was taken for exclusion, I agreed with that 12:25
11 decision.
12 97 Q. The rationale, to the extent that we can divine it from
13 what is said here, is that Dr. O'Brien's administrative
14 practices have led to the strong possibility that
15 patients may have come to harm. Was that the rationale 12:26
16 for the decisions that were made?
17 A. Yes, yes. It was all -- well, my recollection was
18 twofold. It was that patients may have come to harm as
19 a result of, for example, the SAI, but also it was felt
20 better that the investigation could take place by the 12:26
21 operational managers if Mr. O'Brien was to be excluded
22 for a four-week period.
23 98 Q. Mr. O'Brien, by this point, so far as we understand and
24 we'll hear from him, was in the dark about the SAI. He
25 certainly hadn't been given an opportunity to give a 12:27
26 response to the SAI conclusions. Was that noted or was
27 that a factor that was raised within this meeting, do
28 you recall?
29 A. No. I don't recall it being discussed.

1 99 Q. When you think about it now, some of the key issues
2 that were to be investigated under MHPS, so was
3 Mr. O'Brien doing triage of urgent or routine
4 referrals; well, that answer was obvious, wasn't it, he
5 wasn't? 12:28
6 A. Correct.
7 100 Q. Is he dictating on all of his clinical encounters in a
8 timely fashion, and is this causing some degree of
9 uncertainty for the management systems. The answer to
10 that again was obvious, wasn't it; he wasn't? 12:28
11 A. Correct.
12 101 Q. Again, is he keeping notes at home for extensive
13 periods, again causing a degree of difficulty for
14 colleagues and the system that relies on ready access
15 to those notes. Again, the answer to that was obvious, 12:28
16 wasn't it? He wasn't. I assume all of that was
17 realised at this meeting?
18 A. Yes. How you described it, I think when you put those
19 three things together plus the yet to be fully reported
20 SAI, then that made the decision. Helped inform the 12:29
21 decision.
22 102 Q. Yes. What from your perspective, given that the
23 answers to those factual questions were perhaps
24 obvious, what from your perspective directed the need
25 for what became a fairly elaborate MHPS investigation? 12:29
26 A. Sorry, I don't understand.
27 103 Q. If you know these things are happening, what is there
28 to investigate? What is there that merits an elaborate
29 investigation?

1 A. So I think an investigation at this meeting, this
2 Oversight meeting, I think an investigation in terms of
3 MHPS, a formal one, was the right thing to do.
4 Because, as you've just described, those four factors
5 together did not paint a good picture in terms of 12:30
6 Patient Safety.
7 104 Q. I suppose my point to you is this. Maybe I'm not being
8 clear. You, as a committee, knew what was happening.
9 Was it a question of we need to investigate to
10 understand why? 12:30
11 A. I think it was to gather all the data. There were
12 elements we still had to get data on. I think it was
13 to do a bit of more reconnaissance so that we would
14 have a better informed position of the totality of
15 everything. 12:31
16 105 Q. The decision at that meeting was taken without NCAS
17 advice. Again, you've described yourself being
18 something of a stranger to the MHPS framework and its
19 arrangements. Did it strike you as odd that advice was
20 only being sought after a decision, whether in 12:31
21 principle or however it might be described, had been
22 taken?
23 A. No, because I didn't fully appreciate the systems and
24 processes that needed to be followed.
25 106 Q. Did you appreciate what NCAS was? 12:32
26 A. No. At that point, no.
27 107 Q. You obviously set about some follow-up work after that
28 meeting and we'll look at that just in a moment.
29

1 Shortly after the meeting, if we can bring up
2 TRU-01366, you are referred to a further potential SAI
3 in the case of Patient 16. You've seen the name in
4 front of you, have you?
5 A. Yes. 12:33
6 108 Q. We'll call him Patient 16. Behind that email are
7 documents related to concerns that had been expressed
8 about Patient 16. I suppose the issue in the case was
9 whether his care had been properly addressed. There
10 was the need for a removal and, I think, replacement of 12:33
11 stent. Mr. O'Brien was the treating clinician, and
12 you're asked by Dr. Boyce to give a view on that. If
13 I just ask you again - slightly at a tangent to the
14 MHPS process but it arises just after the Oversight
15 meeting - should the issues associated with this one, 12:34
16 Patient 16, have fed into considerations associated
17 with the MHPS process?
18 A. My understanding of Patient 16 originally came in as a
19 complaint. As a result of working through the
20 complaint, then Dr. Boyce sent this email to me. Then 12:34
21 we got into the -- the complaint continues on in terms
22 of being investigated and reported and then it comes to
23 be screened and was deemed to be an SAI. I think it
24 was in April of '17. Its origins were as a complaint
25 by Patient 16's daughter. 12:35
26 109 Q. What I'm really asking you is this. We've seen at the
27 meeting of 16 December that Dr. Boyce is invited or
28 requested to bring forward a report in terms of whether
29 there have been any other complaints about Mr. O'Brien,

1 whether there have been any other IR1s, and here you
2 have, immediately after that, information coming into
3 the system that will ultimately lead to a decision to
4 have an SAI in this case on the back of complaint?
5 A. Yes. 12:35
6 110 Q. What's at the heart of the complaint is, in essence,
7 poor communication with the patient and his family, and
8 delay in the provision of stenting, which leads to that
9 complication. Why is that information not to be
10 considered as part of the analysis of what needs to be 12:36
11 investigated around Mr. O'Brien's administrative
12 practices?
13 A. So, looking in retrospect and knowing what we know now,
14 yes, I think this complaint should have been part of
15 the fourth item in terms of IR1s and complaints against 12:36
16 Mr. O'Brien. It should have been offered up but it
17 wasn't and maybe Dr. Boyce can provide an explanation
18 as to why that was. But I think you make a fair point,
19 it was a complaint.
20 111 Q. Do you think enough work was done by the Trust and, 12:36
21 particularly, the Oversight meeting and those
22 responsible for implementing the decisions which were
23 ultimately to feed into the terms of reference for an
24 investigation. Do you think enough background work was
25 done to try to get to grips with all of the kinds of 12:37
26 perceived shortcomings in association with
27 Mr. O'Brien's practice that were causing difficulty?
28 A. So I've thought about this quite a bit, particularly
29 from March. I used the word that there was no coming

1 together of all views that everybody had. I think that
2 was missing. There was no coming together of all the
3 strands of information that everybody possessed.
4 I think we were moving at quite a fast pace in and
5 around end of December into January to collate the 12:38
6 information. But with hindsight, should there have
7 been weekly meetings of the Oversight meeting saying
8 where are we now? Is there any more information that
9 we have gleaned? How are we progressing with whatever
10 actually needs to be done? That possibly would have 12:38
11 been a much more robust system, but it didn't happen.
12 Forensic is the word I'm looking for.
13 112 Q. Thank you for that perspective.
14
15 Let me ask you about the follow-up work which was 12:38
16 clearly laid at your door to follow-up on after this
17 Oversight meeting. First of all, what did
18 you understand your role to be?
19 A. So, basically one of gathering information, gathering
20 data to help inform the Oversight Committee. 12:38
21 113 Q. You've described that following the meeting you sent an
22 email to Mrs. Corrigan and Mrs. Clayton to take some
23 steps. If we can just look at that, TRU-258675. Hot
24 on the heels of the meeting, just the next day 23rd
25 December, you're writing to both of them to say we need 12:39
26 an action plan to address the following, and you set
27 out each of the four items.
28
29

1 Number 4 is the one I sort of picked up on earlier,
2 Tracy Boyce had that action to complete. But you're
3 asking Martina and Wendy, that's Corrigan and Clayton,
4 to come up with some information around that. The
5 other three, then, you're expecting information on the 12:39
6 volume of notes tracked, what has been the outcome for
7 the 318 patients, and what were the volumes of the
8 patients where there's been no dictation and a plan to
9 correct same.
10 12:40
11 On 28th December, if we look at AOB-01300, you become
12 aware of what I will describe as the private patient
13 issue. That wasn't an issue that was before the
14 Oversight Committee on 22nd September, this was new
15 information being fed in - I think if we look at the 12:40
16 bottom email first - fed in by Mr. Haynes. Then if
17 we look at what he's saying, he's referring here to a
18 TURP patient. He attaches to his email some
19 correspondence in respect of it. We don't need to look
20 at that. But he's saying that there's a private 12:41
21 patient letter from Mr. O'Brien. The patient was seen
22 by Mr. O'Brien on 5th September and placed on the NHS
23 theatre list on Wednesday the 21st, waiting a total of
24 15 days before a TURP procedure is performed.
25 12:41
26 If we scroll up to the top of the page, that issue is
27 drawn to your attention. You say that you've asked
28 Wendy - that's Wendy Clayton --
29 A. Right.

1 114 Q. -- to run a report on Mr. O'Brien's TURPs completed to
2 see are there others who have been listed the same way.
3
4 You get each of those work streams moving and
5 you report back on them at the 10th January Oversight 12:42
6 Committee meeting; isn't that right?
7 A. That's correct.
8 115 Q. I'm going to come to that in a moment.
9
10 Obviously in association with what these preliminary 12:42
11 investigations had discovered, there were obviously
12 clinical issues to be addressed; isn't that right?
13 A. Yes. So we met with the consultant urologists, I think
14 it was 3rd January, and we, I suppose, brought them up
15 to speed with regard to what had been happening with 12:42
16 Mr. O'Brien and the decisions that had been taken.
17 We shared that with them and we asked them for their
18 assistance to work through work that needed to be done.
19 116 Q. I needn't bring this up in ease of the time we have;
20 you deal with that in your witness statement at WIT- 12:43
21 1127. You say that the consultants were willing to
22 work outside of core time or to displace SPA to assist
23 with these investigations. They thought that the
24 untriaged referrals were the greatest clinical concern
25 and that this should be prioritised. Is that a fair 12:43
26 summary of it?
27 A. That's fair, yes.
28 117 Q. They also said, according to your statement, that they
29 would have preferred to accept Mr. O'Brien's opinion,

1 as it would be difficult for them to arrive at any
2 other conclusion not having assessed the patient. Is
3 that in respect of cases that hadn't been dictated,
4 they were hoping to rely on or wishing to rely on the
5 outcome sheets that Mr. O'Brien had completed? 12:44
6 A. That's correct.
7 118 Q. But they said to you that in the event that
8 Mr. O'Brien's opinion led to a disagreement, that they
9 would reassess the patients themselves?
10 A. That's right. 12:44
11 119 Q. I just want to get a sense from you about the impact of
12 these large numbers of patients that were causing
13 concern. What was the impact on the service, whether
14 in terms of distraction from the heavy workload that
15 was always there to be performed in terms of impact on 12:45
16 the other clinicians, impact on budget and finance?
17 A. Yes, you're right, this was a big impact on an already
18 stretched urology service. But each of the
19 consultants, all the consultants, were happy to
20 contribute even with the pressures that existed on a 12:45
21 daily basis. Sorry, happy is not the right word but
22 they understood the work that need to be done. They
23 worked with us to address each aspect of that in terms
24 of clinical prioritisation.
25 120 Q. One issue that they raised with you was the question 12:46
26 of whether Mr. O'Brien was entitled to do private work.
27 Just have a brief look at that. If we go to TRU-00101.
28 If we start at the bottom of the page, please. Thank
29 you.

1
2 This is the 3rd January, as you correctly recall. You
3 are writing to say that along with Mrs. Corrigan and
4 Colin Weir, you met with urology consultants this
5 morning, shared with them all the events that had taken 12:47
6 place, decisions reached, and they had some questions.
7 Number 4 is "What is the Trust's position on
8 Mr. O'Brien undertaking private work and in particular
9 Using Trust secretarial staff to type private patient
10 work whilst off." 12:47
11
12 Just at the top of the page, Mrs. Gishkori purports to
13 answer that by saying: "I'm sure Simon will be able to
14 address the queries below". She wanted to comment on
15 point 4. 12:47
16
17 "Mr. O'Brien is at liberty to do what he wants off ST
18 premises but he cannot use the services of the Trust in
19 the carrying out of his own private work, not unless
20 the secretarial staff do the work outside core hours, 12:47
21 and don't use any of the Trust's facilities".
22
23 She appears to have an understanding that Mr. O'Brien
24 was at liberty, nevertheless, to carry out private work
25 subject to those conditions. 12:48
26
27 If we go to the next page we can see that Mr. Gibson --
28 that's it, yes. Sorry, I'll have to give you the page
29 reference. If we go to TRU-258674. If we go to

1 AOB-01344. Sorry, I've lost the reference. I can't
2 find it.
3
4 The message that seemed to emerge from Mr. Gibson was
5 that given Mr. O'Brien's exclusion under the MHPS 12:50
6 process, he shouldn't be working privately. Was that
7 your understanding?
8 A. Yes, that came from Mr. Gibson's correspondence.
9 I think Dr. Wright, in his evidence, also held that
10 view. 12:50
11 121 Q. Was that the subject of discussion between you and
12 Mrs. Gishkori?
13 A. No.
14 122 Q. She seems to have adopted a different position.
15 A. No. 12:50
16 123 Q. Now, in terms of the other follow-up work that was
17 being conducted by Mrs. Corrigan, as I've said you
18 reported this into the Oversight Group meeting on 10th
19 January. If we bring up the minutes of that, please,
20 first of all. AOB-01363. We can see that you're in 12:51
21 attendance at that meeting. If we scroll down a
22 little, you explain that you have had a meeting with
23 urologists; they were supportive of working to resolve
24 the position. You then proceeded to update the
25 committee on the three issues, plus the fourth, that is 12:51
26 the private patient issue which was to emerge. You set
27 out, in essence, some figures for them. It's recording
28 you as reporting that from June 2015 there are 783
29 untriaged referrals, all of which need to be tracked

1 and reviewed to ascertain the status of these patients
2 in relation to the condition for which they were
3 referred. Four consultants would be participating in
4 this review. We'll come back to that in a moment, I'm
5 just summarising here. 12:52
6
7 Issue 2 is notes at home. At this point you are
8 reflecting that 307 notes were returned from
9 Mr. O'Brien's home and 88 sets from his office, and
10 that there are 27 notes said to be tracked out to 12:52
11 Mr. O'Brien which were still missing. Again, we'll
12 come back on that issue.
13
14 Thirdly, just scrolling down, please, the undictated
15 clinics. Again it's coming through you, I assume, that 12:52
16 there were 668 patients with no outcomes formally
17 dictated, and that's broken down, you say, across a
18 number of clinics.
19
20 Issue 4 then. You say a review of TURP patients 12:53
21 identified nine who had been seen privately, then had
22 their procedure within the NHS. You assert that the
23 waiting times for these patients appear to be
24 significantly less than for other patients. There's
25 then discussion of what remuneration would be needed 12:53
26 for the clinicians carrying out the look-back work.
27
28 If I can work through in a bit more detail some of
29 those issues that are raised. Let's go to the issue of

1 triage. You provided a written report which we have,
2 I think in red ink. Let's just confirm that this is
3 your work, AOB-257706.
4 CHAIR: Is that TRU, Mr. Wolfe?
5 MR. WOLFE KC: Is it? Try TRU-257706. Yes. 12:54
6 124 Q. This is how you presented to the Oversight Group your
7 findings.
8
9 We've seen that prior to the Christmas period, the
10 figure in terms of untriaged cases that was presented 12:55
11 was a figure of 318 cases. How did the figure of 783
12 emerge?
13 A. So, this was a physical search of Mr. O'Brien's office
14 which Mrs. Corrigan undertook, and they were in
15 Mr. O'Brien's filing cabinet, this number. So, it was 12:55
16 a physical search.
17 125 Q. We know that Mr. O'Brien directed Mrs. Corrigan to a
18 drawer or a cupboard within his office where he had
19 retained duplicates of the triage referrals or the
20 referrals that were to be triaged. Are you saying that 12:56
21 the 783 was simply a physical count of that?
22 A. Yes.
23 126 Q. We know that previously we looked at the email this
24 morning where a figure of 318 was given. In other
25 words, that was the figure counted by the system that 12:56
26 had issued the referrals to Mr. O'Brien. Can you
27 explain the disconnect? The system is giving 318 as a
28 figure. Yet, for the purposes of the investigation
29 we're working off this much larger figure based on a

1 count of the letters not returned.
2 A. I can't, really. The information came from the -- the
3 318 came from the referral booking centre,
4 Mrs. Robinson, 318. 783 came from a physical search of
5 Mr. O'Brien's -- the drawer in his cabinet. While 12:57
6 there was a disconnect, I can't provide you with --
7 Mrs. Corrigan may be able to provide you with a better
8 explanation, or an explanation.
9 127 Q. Can I ask you to take a look at TRU-257702. This, as
10 can be seen, appears to be a count of letters waiting 12:58
11 to be triaged taken from Mr. O'Brien's office,
12 according to the legend at the top. Scroll down. It
13 produces the figure of 738. Is Mrs. Corrigan the
14 author of this document?
15 A. Yes. 12:58
16 128 Q. As you say, the title seems to suggest it is
17 essentially a count of the letters.
18 A. Yes.
19 129 Q. If we go back then to TRU-257706. You describe the
20 plan is to carry out an administrative exercise in 12:59
21 association with these letters and ensure that these
22 patients have not already been treated. Then, the
23 remaining letters will be triaged by the four
24 consultants and, after some discussion, it was agreed
25 that in keeping with their normal triaged pathway, that 12:59
26 these letters will need advanced triage, which will
27 take quite a bit of time because of the volumes.
28
29

1 What does that mean, it was agreed that in keeping with
2 the normal triage pathway, advanced triage would be
3 necessary?
4 A. So, my understanding is that they would be sent for
5 diagnostic tests in advance of being seen, if required, 13:00
6 in the outpatient clinic. So ultrasound, CT, any blood
7 work that would be deemed to be clinically appropriate,
8 they would be sent for. The patient would be sent for.
9 130 Q. Is that to suggest that this advanced triage was
10 normally performed by the four consultants? 13:00
11 A. I think Mr. O'Brien had a view of how he viewed
12 advanced triage, and the other consultants had a
13 different view of how they viewed advanced triage.
14 131 Q. Their view was that the approach was more like a
15 traffic light system, it is either stay with the -- 13:01
16 it's look at the referral coming in from the general
17 practitioner and decide simply whether that's an
18 accurate classification or not, whereas Mr. O'Brien
19 went further, much further, and dealt with advanced
20 triage. It is just how that sentence is written: 13:01
21
22 "After some discussion it was agreed that in keeping
23 with their normal triage pathway, these letters will
24 need advanced triage".
25 13:01
26 Is the "their" a reference to the other consultants?
27 A. Yes, the four consultants. I think the four
28 consultants subscribed to a higher degree of triage
29 than just simply a tick box. They would have, to

1 varying degrees, sent them on for other preliminary
2 tests, whereas Mr. O'Brien had his own way of triaging.
3 132 Q. Which was even more developed?
4 A. Which was even more advanced.
5 133 Q. I understand. 13:02
6
7 In any event, is it your understanding that by virtue
8 of this process with the four consultants doing the
9 triage, 24 patients were upgraded to red flag, and four
10 of those patients - perhaps it is four additional 13:02
11 patients, I need to check that point - but four
12 patients were found to have cancer?
13 A. Correct.
14 134 Q. Those patients were 11, 12, 13 and 14, and those cases
15 were the subject of another triage-related SAI? 13:02
16 A. Yes.
17 135 Q. A further patient, a fifth patient, was subsequently
18 identified?
19 A. Yes.
20 136 Q. Thank you. 13:03
21
22 In terms of notes then, if we just scroll down the page
23 and over into the next page. Your report indicates
24 that 307 sets of notes were returned from Mr. O'Brien's
25 home. This included 94 Southern Trust notes that 13:03
26 Mr. O'Brien -- perhaps 94 Southern Trust patients that
27 Mr. O'Brien had seen privately but had written his
28 private notes in these charts.
29

1 Is that the appropriate way to manage private patients
2 at that time? Is that how it was done, if you see
3 somebody privately, you put the private note into the
4 Trust --
5 A. I could be corrected but I don't believe it is. The 13:04
6 private notes should remain private.
7 137 Q. You go on to say that Martina, that's Martina Corrigan,
8 ran a report from past and found there are still 27
9 notes tracked to Mr. O'Brien that were missing.
10 13:04
11 On 24th January you received information from Mr. Weir
12 that Mr. O'Brien had provided explanation for what was
13 ultimately to become 13 sets of notes that were
14 missing. It is accepted by the Trust, isn't it, that
15 Mr. O'Brien doesn't have those 13 sets of notes and 13:05
16 wasn't responsible for their loss?
17 A. That's correct.
18 138 Q. The fact 13 sets of notes have gone missing without
19 explanation, is that something that the Trust has
20 worried about? Is it a source of concern, or is that 13:05
21 put down to being just one of those things when running
22 a busy hospital?
23 A. Well, obviously the Trust is tasked with keeping
24 patients' information secure. So, to have 13 sets of
25 notes not accounted for would be a concern. But 13:06
26 I think these 13 were inappropriately assigned to
27 Mr. O'Brien. I think we have referenced that in the
28 evidence. But I suppose to answer your question --
29 maybe, if I think I understand your question is do

1 I know where those 13 sets of notes are, I don't.
2 139 Q. Yes.
3 A. I know we had discussions with the record people,
4 Pamela Lawson and her team. They may be able to
5 provide some more information to you. 13:06
6 MR. WOLFE KC: I see it is 1.10 nearly.
7 CHAIR: Yes. We have another witness due to start at
8 two o'clock this afternoon, Mr. Wolfe. Are we going to
9 manage?
10 MR. WOLFE KC: She is not likely to be starting at two 13:06
11 o'clock. It is more likely, the way things developed,
12 that she will be starting in the morning. We'll finish
13 Mr. Carroll today.
14 CHAIR: Okay. It is probably too late to stop her
15 coming this afternoon, but if we can get some message 13:07
16 to her, I think we have to try.
17
18 Ten past two, everyone.
19
20 THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS: 13:16
21
22 CHAIR: Good afternoon, everyone.
23
24 Mr. Wolfe.
25 140 Q. MR. WOLFE KC: Mr. Carroll, we were going through the 14:10
26 report that you making to the 10th January 2017
27 Oversight Committee meeting.
28
29 Going now to look at your report on dictation. If we

1 could have up on the screen, please, TRU-257707. You
2 say:
3
4 "Martina ran a report of all the undictated clinics
5 from the Business Objects Group and found that this 14:11
6 related to 668 patients dating back to November 2014".
7
8 Obviously we saw before lunch that Mrs. Elliott had
9 provided a figure of 61 clinics in the pre-Christmas
10 period. 14:11
11
12 Business Objects, is that a -- you're looking at me
13 puzzled. Do you know what that is?
14 A. I do. I've never used it. It's a performance tool
15 which exacts data from the information systems. I'm no 14:11
16 expert.
17 141 Q. We'll have to ask Martina Corrigan how this 668 figure
18 is arrived at, but it's not something you tested
19 yourself?
20 A. No. 14:12
21 142 Q. Or challenged?
22 A. No.
23 143 Q. You were given the figure and that was the figure that
24 was supplied to Dr. Chada's investigation?
25 A. Yes, yes. Mrs. Corrigan's background would be in 14:12
26 administration and systems.
27 144 Q. Yes.
28
29

1 Now, obviously this is a report provided to the
2 Oversight Committee. If we just scroll down, there's a
3 plan of checks to be made with the lists of undictated
4 clinics. It said that effort had been made to identify
5 the 97 patients. That's relates to what's described as 14:12
6 a shortfall in the handwritten outcome sheets coming
7 from Mr. O'Brien?
8 A. Correct.
9 145 Q. Mr. O'Brien brought back the patient charts. Then it
10 became known through Mr. Young, as I understand it, 14:13
11 that Mr. O'Brien had indicated that he had retained
12 patient outcome sheets, his handwritten outcome sheets
13 and then they came back to the Trust on the 9th
14 January. Counting them up, there were 272 outcomes
15 from the SWAH clinic, 229 from other clinics, and out 14:13
16 of the 668, there was 97 which hadn't been provided.
17 On that analysis, do you know whether that was resolved
18 in any way?
19 A. Yes. I think Mrs. Corrigan was able to work through
20 the information she had so that when we get to June, 14:14
21 by June 17th, all the patients had been accounted for.
22 146 Q. Yes. There was an email sent in June by Mrs. Corrigan
23 to yourself which we can maybe look at in that respect.
24 It's TRU-258863. Just so the Inquiry and everyone else
25 knows and understands, you're reporting this 14:14
26 information into he Oversight Group, and I'm taking you
27 along the line to where this information, as part of
28 your team's follow-up on it --
29 A. Yes.

1 147 Q. -- where it takes you to.
2 A. Correct.
3 148 Q. It should be understood, I think, that the information
4 that your team is gathering is then being fed into
5 Dr. Chada's investigation in terms of, if you like, the 14:15
6 statistics relied upon by the service --
7 A. Yes.
8 149 Q. -- I suppose to support the allegations or concerns
9 that have been identified; is that fair?
10 A. That's fair. 14:15
11 150 Q. So, the work that's been done in this, I suppose
12 parallel investigation, by both your team and the
13 clinicians who are tasked with looking at the
14 undictated clinics leads to this conclusion, that there
15 are 110 patients who are being added to a review 14:15
16 outpatient waiting list.
17
18 Just help me with that. Does that mean that when these
19 undictated clinics or undictated patients were being
20 examined by the clinicians who were doing the work, 14:16
21 that they found that there was 110 patients who should
22 have been on the review outpatient list if Mr. O'Brien
23 had been doing it as you would have expected?
24 A. Yes, that's correct.
25 151 Q. It said a number of these should have had an 14:16
26 appointment as per Mr. O'Brien 's handwritten clinical
27 notes before now. They should have had an appointment
28 issued to them; is that what it is saying?
29 A. Yes.

1 152 Q. Although the caveat that Mrs. Corrigan is offering is
2 that Mr. O'Brien has a review backlog issues, that
3 these patients, even if they had have been added
4 timely, may still not have been seen?
5 A. Yes. 14:17
6 153 Q. So in a sense, no loss to patients?
7 A. No, they hadn't been disadvantaged in terms of being
8 seen at the review appointment.
9 154 Q. Yes.
10 14:17
11 Then it is said there are 35 patients who need to be
12 added to a theatre waiting list. All of these patients
13 he has classed as Category 4, which is routine. Again,
14 due to the backlog -- I don't think she finishes that
15 sentence. Again, due to the backlog, they probably 14:17
16 wouldn't have received their theatre appointment by
17 this stage?
18 A. Yes.
19 155 Q. But again, is the point here that the Trust doesn't
20 have these 35 on the list? 14:17
21 A. Yes, exactly. For both the outpatients and the ins and
22 days when you would be running the list, they would be
23 short those number of patients.
24 156 Q. Just scrolling down, she has attached Mr. O'Brien's
25 sheets. He's gone through all the charts that were in 14:18
26 the AOBs office and will be back in the records
27 tomorrow.
28
29

1 Katherine Robinson's team are currently recording the
2 outcomes and these will be backdated to when the
3 clinics happened. Is this in order not to disadvantage
4 the patients?
5 A. Yes. 14:18
6 157 Q. They will achieve a place on the waiting list --
7 A. At the correct time.
8 158 Q. -- at the correct time.
9
10 It says there are three patients consultants who have 14:18
11 concerns on, and she has arranged appointments for
12 them. Then she offers the following comments.
13 Patients -- I think she's attempting to summarise
14 there, is she, the broad findings?
15 A. Sorry, I think what Mrs. Corrigan is attempting to do 14:19
16 is summarise the findings the consultants made when
17 they reviewed the patients.
18 159 Q. If we scroll -- just if we go back in the direction
19 we've come and go back to the top of page 63 in that
20 sequence. You are here thanking Martina for this large 14:19
21 piece of work. You say you accept that Mr. O'Brien had
22 a long review backlog and routine waiting times are
23 long, but you say the crucial thing is that the Trust
24 was totally unaware of these patients in that there
25 were no PTLs. 14:19
26
27 What's PTL, remind me.
28 A. Primarily target lists, so the waiting list.
29 160 Q. The implication you're describing here of the failure

1 to dictate is one of administrative distress or
2 inconvenience for the organisation; is that it?
3 A. Yes, and for the patient in that the patient is not on
4 the waiting list, you know. They haven't been advised
5 of the outcome of their appointment and what the 14:20
6 outcome of that is, in that you're going to be reviewed
7 or you're going to go on the waiting list.
8 161 Q. I suppose, for that matter, their primary care --
9 A. The GP.
10 162 Q. -- their GP is unsighted on what's planned? 14:20
11 A. Yes, correct.
12 163 Q. Mr. O'Brien made the case to Dr. Chada that when
13 you consider what dictation had or hadn't been done,
14 the proper figure to arrive at is 189 cases, and we'll
15 hear from him on this, perhaps. He says that he 14:21
16 gleaned some support from Martina Corrigan's analysis
17 of the patients. He thinks his 189 figure is consonant
18 with what she has said in that email. I'll have to ask
19 him to explain that.
20 A. Okay. 14:21
21 164 Q. Could I ask you this: It appears that he made that
22 case about the much lower number, 189 as opposed to
23 668, very loudly and very clearly to Dr. Chada.
24 She didn't come back to you or anybody in your service
25 to ask you to test those figures? 14:22
26 A. No.
27 165 Q. Could I just ask you to look at your witness statement.
28 WIT-13162, please. At paragraph 359, you're dealing
29 with the issue of untriaged referrals. Then you go on

1 to say:
2
3 "The Undictated clinics were completed on
4 return-to-work in February as Mrs. Corrigan had not
5 scheduled Mr. O'Brien into any clinics until the end 14:23
6 of July 2017".
7
8 Does that suggest that you believed that Mr. O'Brien
9 was dealing with the dictation work? Or can you help
10 us with the meaning of that? 14:23
11 A. I'm struggling to understand it myself. So, I am clear
12 that Mr. O'Brien -- the number of 668, from our
13 perspective -- Mr. O'Brien brought in clinical outcome
14 sheets for the number, and there was a gap of 197.
15 When Mr. O'Brien came back to work, because the work is 14:24
16 planned six weeks ahead, there was no elective work or
17 plan for Mr. O'Brien, so he was allocated time to do
18 his administrative work. Thinking back, he could have
19 helped in some way to help with those patients who
20 there were no outcome. I suppose the total clinical 14:24
21 outcome sheets needed to be recorded into the patient
22 notes and into NACR. I think that's what I was trying
23 to get at but we know the task wasn't finished
24 until June in total.
25 166 Q. I suppose the point is, as I understand it, and we may 14:25
26 hear some evidence on this, Mr. O'Brien would make the
27 point that the records for these patients were not
28 returned to him for dictation purposes.
29 A. This is when he returned to work?

1 167 Q. Sorry?
2 A. When he returned back to work?
3 168 Q. Yes. You seem to be suggesting that the undictated
4 clinics were completed on his return to work
5 in February. Two points: One, the records of these 14:25
6 patients were not returned to Mr. O'Brien for the
7 purposes of dictation and, secondly, he didn't return
8 to clinic work until -- sorry, he returned to clinic
9 work in March and not July, as suggested here.
10 A. Well, maybe I have -- the word "completed" is 14:26
11 incorrect.
12 169 Q. The work on the dictation, looking through the cases
13 that hadn't been dictated, that was done by his
14 colleagues?
15 A. Yes. 14:26
16 170 Q. Not by Mr. O'Brien?
17 A. No.
18 171 Q. And he returned to clinic work in March --
19 A. In March.
20 172 Q. -- albeit on a managed basis? 14:26
21 A. Yes.
22 173 Q. The final issue that you were reporting into the
23 Oversight meeting in January was in respect of private
24 patients. That was an issue that, as we have seen, had
25 just arisen after the December Oversight Group meeting. 14:26
26 Let's just look at the steps that followed.
27
28 If we go to TRU-257703. Scroll down to we see it.
29 We have here from Mrs. Clayton an email where she says:

1
2 "All the patients had a" - and this is Mr. O'Brien's
3 address - "private letter on the NIECR. It doesn't
4 mean there could be more but no private letter on
5 NIECR". 14:28
6
7 So, she sets out, I think, eight incidents. I think if
8 that redaction weren't there, it would be in relation
9 to six, possibly seven patients. They were all, at
10 your direction, TURP patients. This was research into 14:28
11 those who had had a TURP procedure; is that right?
12 A. That's correct, yes.
13 174 Q. Your interest in this was to see whether these patients
14 who originated as private had received a
15 quicker-than-usual procedure within the NHS? 14:28
16 A. That's correct. Yes.
17 175 Q. Do you know by which method she used to conduct this?
18 A. So, she looked at all the patients -- my understanding
19 is, again, she looked at all the TURP patients that
20 Mr. O'Brien operated on in 2016 and then looked to see 14:29
21 which one of those patients had been seen privately,
22 and she then produced this table.
23 176 Q. Yes. Unfortunately with this redaction, I can't
24 illustrate the next point, but would you accept or
25 would you have an understanding that only one of the 14:29
26 patients on this list was to form part of the 11
27 patients that were ultimately considered by Dr. Chada's
28 investigation? There was another patient, that was the
29 patient referred initially by --

1 A. Mr. Haynes.
2 177 Q. -- Mr. Haynes, who was part of the 11. But not all of
3 these patients were to form part of the 11 that was
4 considered by Dr. Chada; isn't that right?
5 A. That's correct. 14:30
6 178 Q. I just want to explore with you on how that came about.
7 A. Yes.
8 179 Q. She has produced that list. If we go to AOB-03164, I'm
9 just going to jump about a number of entries. If
10 we pull up the bottom entry. We looked at this briefly 14:30
11 earlier. A review of TURP patients; it says it
12 identified nine. I don't see nine in that list that
13 we looked at earlier. Some of the entries look to be
14 the same patient in twice. We'll not worry too much
15 about the nine. Then, had the procedure within the 14:31
16 NHS. "The waiting time for these patients appeared to
17 be significantly less than for other patients".
18
19 Is that your language or is that hers?
20 A. I think this is the minutes of the note? 14:31
21 180 Q. Yes, this is you.
22 A. This is me feeding the information to the Oversight
23 Committee and their recording of what I said. The
24 table that you've just made reference to was the first
25 table of patients at a very high level of what I had 14:31
26 asked to do, patients who had TURPs under Mr. O'Brien.
27 What we were showing was there were these eight,
28 plus -- although we make reference to the ninth, I
29 think the ninth was Mr. Haynes' patient we were making

1 reference to. Just simply the waiting time and drawing
2 the interference from that. So the column, I think it
3 was the penultimate column, shows the number of days
4 they were waiting before they were operated on.
5 I think what we were putting that against was the 14:32
6 waiting time for, the total waiting time for TURPs,
7 which was, I think, 130/140 weeks. And these patients,
8 I think the longest was 200 days.
9
10 We were just saying the waiting time is 130 weeks, 14:32
11 these patients seen privately by Mr. O'Brien are
12 waiting considerably less.
13 181 Q. Yes. Well, that's the theory or the approach. Let's
14 just work through what happens then. On 16th January,
15 Ms. Clayton sends you an email showing 847 patients who 14:33
16 attended Mr. O'Brien for surgery in 2016. Let's get
17 that up on the screen, TRU-263732. We can look behind
18 that email if necessary, but she's sending you all of
19 Mr. O'Brien's urological surgery for that year. At
20 this point, was she being asked to expand her terms of 14:34
21 reference into other procedures other than TURPs?
22 A. I do not recall how we got from my request for TURPs to
23 be looked at to all of Mr. O'Brien's surgery. I've
24 tried to trace the emails to see how Ms. Clayton was
25 given the instructions. I have no doubt it could have 14:34
26 been me that said it to her, but in terms of me
27 recalling why I said it to her, I can't find any
28 communication or evidence for the rationale behind
29 that.

1 182 Q. It is fair to say, isn't it - and we saw the email this
2 morning - that the initial interest is TURPs.
3 A. Yes.
4 183 Q. Or TURP?
5 A. Because that was the operation Mr. Haynes made 14:35
6 reference to.
7 184 Q. If we pull up TRU-258862. Scroll down again, please.
8 In response to the 16th January email, you say to her -
9 just up a little - on 29th January you need to work
10 through these patients to identify any who were 14:35
11 operated on against chronological management.
12
13 How can you do that? What does chronological
14 management mean in that sense?
15 A. I think we were, again, looking at those patients 14:36
16 Mr. O'Brien had seen privately. I think there is
17 somewhere in one of the emails where I had asked --
18 Mrs. Clayton had presented that 16th email data, and
19 I had asked for guidance on how we should approach
20 this. Should we look at all the patients, should 14:36
21 we sample a few of the patients or none of the
22 patients. I think I sent that to Dr. Wright and
23 Mrs. Gishkori. I don't recall -- I can't see any
24 evidence of getting a reply from them.
25 185 Q. Okay. We'll try to find that email. 14:36
26
27 The next step that we're currently aware of is on
28 8th March, Ms. Clayton has gone through all of the
29 surgeries and she's identified 11 private patients.

1 We'll just pull that up, please. It's TRU-258769.
2 She's telling you:
3
4 "I have gone through patients that had surgery under
5 AOB in 2016. There were 11 patients with a hermitage 14:37
6 letter who did not wait long for their surgery. See
7 the below. There were 830 patients in total who had
8 surgery in 2016". You have a hard copy of the hermitage
9 letter".
10 14:37
11 Then scrolling up the page, you say:
12
13 "Wendy, thanks, and you will kill me (possibly) what
14 procedures did they have? And then compare to the
15 other patients classed as urgent awaiting the same 14:37
16 procedure to see is there a difference. This would be
17 important."
18
19 Does that suggest that you thought it important to
20 compare like with like, there had to be fair 14:38
21 comparative analysis?
22 A. Of course. I mean, we had to be fair to Mr. O'Brien
23 that if we were -- yeah, we had to be fair to
24 Mr. O'Brien. So I had asked Wendy to detail the
25 procedure and what was the waiting time for those same 14:38
26 patients who were not seen privately by Mr. O'Brien.
27 186 Q. Can you explain to us how the nine, if we can call it
28 nine - I'm not entirely sure that it is nine TURP
29 patients but let's work with that figure - how, at

1 least six and possibly seven of that original
2 nine didn't then follow into the Chada investigation.
3 They were, if you like, discarded; they didn't form
4 part of this analysis going forward.
5 A. I don't think I can, except the patients we felt were 14:39
6 appropriate, we asked Mr. O'Brien -- Mr. Young to
7 review them from a clinical perspective to see what his
8 views on the waiting time were against the condition.
9 So, I don't know how the nine initial TURP patients
10 were not then factored into -- or removed from the 11, 14:39
11 the 11 which Mr. Young reviewed.
12 187 Q. Yes. It is fair to say, and we can see various
13 examples of it, this minute to the Oversight Committee
14 in January has you asserting that these nine appear to
15 have been treated quicker than comparable patients who 14:40
16 hadn't gone private. Similarly, when Mr. O'Brien meets
17 Mr. Weir on the 24th January, again it's the nine TURP
18 patients. He is being told the concern is these TURP
19 patients have been seen -- these private TURP patients
20 have been seen quicker. 14:40
21 A. Yes.
22 188 Q. I wonder can you help us with this, I don't have any
23 analysis from Mr. Young showing how these TURP patients
24 have been discarded from having been patients of
25 concern to this investigation. How have they fallen 14:41
26 out?
27 A. I'm unclear also so I don't have an answer for you,
28 Mr. Wolfe, as to how the original TURP patients were
29 then not -- did not find their way into the next set of

1 nine which Mr. Young reviewed.
2 189 Q. Yes.
3 A. I suppose what I would say is that the initial table
4 that Ms. Clayton produced was simply waiting times for
5 those patients. It wasn't whether or not they were 14:41
6 clinically appropriate to be done, because we hadn't
7 asked any clinician to review them. It was simply just
8 stating a fact that on the face of these patients who
9 had seen Mr. O'Brien, they had waited a considerably
10 less time than the waiting time for TURPs. 14:41
11 190 Q. Nor does it seem you are able to clearly explain how
12 you moved from an interest in the nine TURP patients
13 into patients receiving other surgical treatments or
14 diagnostics. There doesn't seem to be on the face of
15 the papers or on your evidence so far a clear 14:42
16 explanation as to how that turn was taken?
17 A. I know. I accept that. I am unable to provide an
18 explanation as to why it went from TURPs to all surgery
19 in 2016.
20 191 Q. The concern which was expressed by Mr. O'Brien to 14:42
21 Dr. Chada and to Dr. Khan and in his grievance
22 subsequently was that having realised as a service or
23 as an organisation that the allegation in respect of
24 TURPs couldn't be made out across the nine patients, a
25 vexatious turn was made to look at other patients who 14:43
26 might fit the charge. Do you follow?
27 A. Yes. I do follow and I have read Mr. O'Brien's view on
28 that.
29 192 Q. In other words, he was suggesting - I'll choose my

1 words carefully - he uses the word "vexatious", to try
2 to undermine, impact on his reputation by unfairly
3 picking out patients who, to repeat the words, might
4 look as if they better meet the charge of unfair
5 advantage once you realise that the TURP patients 14:43
6 couldn't bring the case against him home. Is that what
7 happened?
8 A. In what respect, sorry?
9 193 Q. Was there some calculation made here that, well,
10 Mr. Young won't stand over the allegation -- Mr. Young 14:44
11 won't stand over the charge in respect of the handling
12 of these TURPs patients so we better go and find some
13 other evidence to hang Mr. O'Brien with?
14 A. No, definitely not. I mean, what we did was all in
15 good faith. There was nothing other -- no other 14:44
16 intention or purpose or reason behind. It was simply
17 taking Mr. Haynes' email and investigating it. That's
18 how it was set out.
19 194 Q. In terms of what has been done here by Mrs. Clayton -
20 you sent her off to do a further body of work - can you 14:45
21 explain the process which then led to these matters
22 going to Mr. Young for consideration?
23 A. No, I can't. I mean, I think Mrs. Corrigan would be in
24 a better position to answer that than I would be.
25 195 Q. Did you ever have a conversation with him in relation 14:45
26 to this?
27 A. No, I never had a conversation with Mr. Young.
28 196 Q. Mrs. Corrigan may be the more appropriate recipient of
29 these questions. If we pull up TRU-283681. This is

1 Mrs. Corrigan explaining in to Siobhán Hynds, copying
2 the investigator, Dr. Chada. She explains - you have
3 this high level explanation to the process that was
4 undertaken - you had requested Wendy Clayton to produce
5 a report or to have a report run on all Mr. O'Brien's 14:46
6 surgery during 2016. That's correct?
7 A. Yes.
8 197 Q.
9 "Any patients that had a short wait time before being
10 added to the waiting list and being operated on had 14:46
11 their record checked on NIECR to see if they had a
12 private patient letter. Out of this list, there were
13 11 patients for which all the letters were printed
14 off".
15 14:47
16 Obviously, the TURP patient issue came before that and
17 you don't have an explanation as to why some of those
18 nine were discard. Otherwise, that's a correct
19 description of the process, is it?
20 A. Yes. 14:47
21 198 Q. It said she then asked Mr. Young if he could look at
22 these letters and gauge from his clinical opinion
23 should they have been seen - I think it says - "should
24 be seen as soon as they had been or should they have
25 been added to the NHS waiting list to wait and to be 14:47
26 picked chronologically.
27
28 That conversation with Mr. Young, is that something you
29 don't know anything about?

1 A. No.
2 199 Q. What was your understanding at that time - these are
3 all 2016 cases, as we understand it - of how a
4 clinician seeing a patient privately should manage that
5 patient on to the NHS? How was that to be done? 14:48
6 A. My understanding is they fill in a form. They transfer
7 the care of the patient from the private sector to the
8 NHS.
9 200 Q. Was that the system in place in 2016?
10 A. I believe so, yes. 14:48
11 201 Q. Who would receive that form then?
12 A. So, it's the secretary. The secretary would fill it
13 in. Where it would go to, I don't know is the honest
14 answer.
15 202 Q. Is it the completion of that form which then places the 14:48
16 patient on the HSC waiting list?
17 A. Yes. There is a process that is meant to be followed
18 when a patient is seen privately and they are returned
19 back to the NHS. There's a process that's meant to be
20 followed. 14:49
21 203 Q. This, I suppose important, issue of chronological
22 dealing or management of a patient, can you help us
23 understand that; how does that work? Presumably, for
24 example, not every TURP patient is as urgent as the
25 next. Would there be gradations of clinical 14:49
26 complication with each patient that might affect how
27 that patient is to be seen?
28 A. Yes. So if a clinician sees a patient and the
29 clinician makes a decision as adding to the waiting

1 list, they do so by categorising them whether they are
2 routine or urgent. If they are either of those things,
3 then they go on at the date -- you know, the
4 appropriate date. Then, they wait from that time that
5 they're placed on the waiting list. 14:50
6 204 Q. Obviously Mr. Young conducted some work in relation to
7 the 11. Again, just to be clear, that wasn't something
8 that was overseen, considered or discussed by you in
9 any way?
10 A. No. 14:50
11 205 Q. Mr. O'Brien criticises the exercise performed by
12 Mr. Young because, he says, it didn't engage in a
13 comparative analysis or an appropriate comparative
14 analysis. In other words, he would maintain, it seems,
15 that all of the 11 patients were treated at a time in 14:51
16 accordance with their clinical merits, and he would say
17 it seems that Mr. Young didn't look at it in that way.
18 A. Well, all I can say is Mr. Young is an equally senior,
19 experienced clinician, surgeon. He was the clinical
20 lead. When Mrs. Corrigan asked him to review it, it 14:52
21 would be for his professional opinion.
22 206 Q. Dr. Chada, I think, accepts that having received
23 Mr. O'Brien's quite detailed and comprehensive analysis
24 of how he treated these 11 patients and why and his
25 observations on the relevant timeframe, she didn't 14:52
26 check back with Mr. Young, didn't check back with the
27 service to test Mr. O'Brien's response. Is that fair,
28 you didn't hear back from her on this issue?
29 A. No, no. From Dr. Chada, no.

1 207 Q. Can you help me with this. Across all of these issues,
2 plainly the Service - the Trust management is maybe
3 another way of putting it - is through you and through
4 your staff, sending information into the investigation.
5 This parallel clinical investigation, if you like, is 14:53
6 producing this data; it's going into the investigation.
7 But it appears to be accepted without coming back to
8 you or your staff to test it at any point; is that
9 right?
10 A. Yes. The information that I would have received, 14:53
11 I would have received from Ms. Clayton and
12 Mrs. Corrigan, both of them equally competent senior
13 managers who would be much more expert than I would be
14 in systems and processes. So, the data that they gave,
15 I didn't test it but I took assurance from their 14:54
16 expertise in this field.
17 208 Q. A case conference happened in late January,
18 26th January. You had obviously attended the previous
19 two Oversight Committee meetings. You didn't attend
20 that one. Mrs. Gishkori didn't attend that one, that 14:54
21 is the one on the 26th January. Do you have an
22 understanding why you weren't asked to go?
23 A. I know now why I wasn't asked to go from listening to
24 Mrs. Toal's evidence, that she sent an email to
25 Mrs. Gishkori requesting that I would not attend as 14:55
26 I was collecting the data, and so Mrs. McVey was asked
27 to go.
28 209 Q. Mrs. McVey was another Assistant Director within the
29 Acute Directorate?

1 A. Yes. So she was responsible for medicine on scheduled
2 care.
3 210 Q. She had no prior background or knowledge, to the best
4 of your knowledge or appreciation, of these Aidan
5 O'Brien issues? 14:55
6 A. No, that's correct.
7 211 Q. Mrs. Gishkori can account for her own reasons for not
8 attending. Could I ask for your observations on this.
9 Was Mrs. Gishkori, to the best of your understanding,
10 fully engaged on these matters? 14:56
11 A. I suppose at the time I didn't, but with reflection and
12 looking at all the evidence and the data, Mrs. Gishkori
13 seems to be arm's length in terms of communication and
14 correspondence and moving things forward, would be my
15 view now. 14:56
16 212 Q. The work that you were doing pursuant to the actions
17 agreed at the Oversight Group in December and then
18 again in January, were they issues that you just got on
19 with, for example with Mrs. Clayton and Mrs. Corrigan,
20 without any input from Esther Gishkori? 14:57
21 A. Yes. Yes, that would be fair to say.
22 213 Q. Did she seek to engage with you on them?
23 A. I don't have any memory of us actually having a meeting
24 or a discussion about it. Now, she may have a
25 different view but I don't recall having meaningful 14:57
26 discussions about being asked for updates as to where
27 we were in terms of progressing the issues, would be my
28 view.
29 214 Q. I ask that question from the perspective that the

1 information that you were generating in association
2 with Mr. O'Brien's practice - failure to triage urgent
3 and routine referrals; failure to dictate outpatient
4 encounters in some clinics; the private patient
5 concern; the sheer volume of notes retained at home, 14:58
6 they raise, do they not, substantial governance issues
7 and management issues for her directorate?
8 A. Yes. Absolutely, yes. Yes. But if the question is
9 did Mrs. Gishkori act on that, well, I'm not here to
10 answer for Mrs. Gishkori, she'll answer for herself, 14:58
11 but I think the answer to that would be apparently no,
12 in my view.
13 215 Q. The case conference - we can bring the document up in a
14 moment - it raised a number of actions for you and
15 Mrs. Gishkori. There was to be a monitoring plan in 14:59
16 respect of Mr. O'Brien to facilitate his return to work
17 following exclusion, and there was to be a comparison
18 of workload activity. We'll maybe just turn that up
19 and we can look at that. Sorry, just allow me a
20 moment. We'll come back to that, I'll deal with it 15:00
21 separately. Those were two issues that you were aware
22 that you were required to take forward?
23 A. So, I don't think I was aware. I've looked. The
24 minutes of the meeting, I didn't receive of the 26th.
25 I've looked in the archives and I've looked in the 15:00
26 evidence bundle. I don't recall receiving them.
27 216 Q. Let's just bring them up briefly at this point.
28 TRU-00037. If we go to the bottom of the next page.
29 It was indicated an formal investigation would take

1 place.
2
3 Then, scrolling down. As a condition of lifting
4 exclusion, the minute records:
5 15:01
6 "It was agreed that the operational team would provide
7 the detail for a monitoring arrangement. This would be
8 provided to the case investigator, case manager and
9 members of the Oversight Committee".
10 15:02
11 Over the page, please. It says:
12
13 "It was noted that Mr. O'Brien had identified workload
14 pressures as one of the reasons he had not completed
15 all administrative duties. There was consideration 15:02
16 about whether there was a process for him highlighting
17 unsustainable workload. It was agreed that an urgent
18 review of Mr. O'Brien's job plan was required".
19
20 Obviously Mrs. McVey was the Directorate's 15:02
21 representative, I suppose, at that case conference of
22 the Oversight Committee. Are you saying that that
23 information regarding those actions didn't filter back
24 to you?
25 A. Yes. There was an email on the -- I think it's 15:02
26 sometime early February from Mrs. Gishkori to
27 Mrs. Hynds and then I'm copied into it, where she asks
28 to meet with Siobhán and me to progress the first one,
29 the terms of the monitoring plan.

1
2 In terms of the other one which has my name beside it,
3 in terms of comparable workload activity with job plan
4 sessions, I didn't action it because I don't think I
5 was aware of it. 15:03
6 217 Q. Who should have been notifying you of it?
7 A. Well, Esther and/or Anne, Mrs. McVey.
8 218 Q. Clearly that was an important consideration or an
9 important action from the perspective of the Oversight
10 Committee in that they're trying to balance the need 15:04
11 for exclusion as against whether the option of a safe
12 return is something that could be contemplated, and
13 they have to have a think about, or they're anxious to,
14 it seems, consider whether there is anything in
15 Mr. O'Brien's workload activity that would be 15:04
16 unsustainable and lead them into further difficulty?
17 A. Yes. I suppose the timeline, I know from the note of
18 the meeting in March, Mr. O'Brien and Mrs. Corrigan and
19 Mr. Weir, Mrs. Corrigan was able to demonstrate to
20 Mr. O'Brien in terms of inpatients and day cases that 15:05
21 he didn't have the biggest volume or the longest
22 waiting list among his peers.
23 219 Q. Let's just park this. We'll come back to this as a
24 standalone issue in just a moment. I just want to pick
25 up a couple of miscellaneous or separate-type issues 15:05
26 that follow in the period after this case conference.
27
28 If we can pull up TRU-267904. This is you providing
29 Dr. Chada's investigation with an update. Were you

1 conscious that the work of the Service and the
2 conditions dealing with these look-back type issues -
3 dealing with the triage, dealing with the undictated
4 patients - that this was work that needed to be done in
5 order to allow the broader MHPS to proceed 15:06
6 expeditiously ?
7 A. Yes. These patients were the outcome of the 24
8 patients -- sorry, the 24 -- this is an update from the
9 24 patients who were upgraded, of the 783 patients.
10 220 Q. If we just scroll down to the bottom, please. I will 15:06
11 just check my reference. If we scroll up. I have a
12 reference but it doesn't appear to be in this document.
13
14 You're telling Dr. Chada, by the 3rd March I think,
15 that the outcome of undictated clinics essentially has 15:07
16 not started by this point. Now, as we saw from
17 Mrs. Corrigan's email earlier, it was completed
18 certainly by June. What was holding up progress on the
19 undictated clinical issues?
20 A. You just couldn't scroll down to see the date on this 15:08
21 email?
22 221 Q. This email is 3rd March, I think.
23 A. Okay. I suppose getting to June, where the undictated
24 patients were finally addressed, generally there were
25 only four consultants doing it. They were doing their 15:08
26 day-time job. I also think they had committed prior to
27 this to doing waiting list work. So, they were doing
28 lots of work. They felt in terms of clinical
29 prioritisation, the first tranche that should be done

1 was the 783 and then they would get to the 668 patients
2 where there was no outcomes of the 97. So they would
3 get to that. It was in the context of everything the
4 Urology Service was doing.
5 222 Q. Simply you didn't have the capacity to do it as quickly 15:09
6 as you would have liked to have done it?
7 A. Yes, correct.
8 223 Q. You mentioned just a moment or two ago the meeting that
9 took place between Mrs. Corrigan, Mr. Weir and
10 Mr. O'Brien in early March which looked at aspects of 15:09
11 his workload. I just want to look at that briefly with
12 you. TRU-258781. In the middle of the page, please.
13 Mrs. Corrigan is writing to you, saying:
14
15 "Colin and I were to meet with Aidan on Monday to 15:10
16 discuss SWAH and other issues that Aidan had on his
17 return to work and Colin had intended to use it as a
18 forum for discussing any issues such as nonattendance
19 at MDT".
20 15:10
21 That meeting happens on the next day, the 9th March.
22 What is your understanding of why that meeting was
23 necessary?
24 A. I think it was just a return-to-work interview after
25 him being off sick. I think that was the purpose of 15:10
26 the meeting.
27 224 Q. If we pull up the minutes of it, TRU-269952. As you
28 say, the minutes look at various aspects of
29 Mr. O'Brien's workload. You say you weren't aware of

1 the requirement for a comparative or comparable
2 exercise, but it does appear that this meeting sought
3 to engage Mr. O'Brien in discussions about how he could
4 better manage his workload.
5 15:11
6 Did you receive any feedback arising out of this
7 meeting?
8 A. Mrs. Corrigan asked me to review it before she sent it
9 out.
10 225 Q. The? 15:11
11 A. The note of this meeting.
12 226 Q. Yes. After the meeting, did you receive any feedback
13 from it?
14 A. No. No, I don't believe so.
15 227 Q. One of the issues which was dealt with was in respect 15:12
16 of the Enniskillen clinics, as we can see here,
17 scrolling down the page. There was an emphasis on
18 ensuring that Mr. O'Brien was in a position to dictate
19 as efficiently as the service wanted it.
20 15:12
21 If we scroll down the page a bit further.
22 Mrs. Corrigan was going to check to see if Mr. O'Brien
23 could use his laptop in SWAH to do his digital
24 dictation. Mr. Young is going to SWAH on the 13th and
25 has agreed to trial and report back. It was agreed 15:13
26 that Mr. O'Brien would see 16 patients on these clinics
27 and he would get one hour to dictate at the end of the
28 clinic.
29

1 "Mr. O'Brien agreed to this and that he would not leave
2 SWAH until all the charts had been dictated on.
3 Mr. Weir asked Mr. O'Brien was this fair and
4 Mr. O'Brien replied "Nothing about job plans was fair".
5 15:13
6 In any event, this grant of an hour to dictate at the
7 end of a clinic day in Enniskillen, is that something
8 additional to what he had had previously?
9 A. I don't know the answer in terms of what was detailed
10 in his job plan. I suppose I read it that the 15:14
11 clinics -- there are two clinics, an a.m. clinic and a
12 p.m. clinic. So, he could be getting two hours to
13 dictate, one for each clinic.
14 228 Q. In terms of how this is being described, I don't know
15 if you can deal with it, it does seem to be something 15:14
16 extra in recognition of the difficulties in dictating
17 as contemporaneously or as quickly as the Service would
18 like.
19 A. Yes. I'm not a clinician, a doctor, but Mrs. Corrigan
20 and Mr. Weir were there, and Mr. O'Brien, 15:14
21 notwithstanding his last comment, agreed. He agreed
22 that that was a reasonable offer.
23 229 Q. I suppose the point being is it a recognition - and
24 maybe it is fairer to ask Mrs. Corrigan this - is it a
25 recognition that he hadn't been given sufficient time 15:15
26 previously to get through all of the dictation
27 requirements that these clinics throw up?
28 A. Well, yes. We would need to see what was in his job
29 plan in terms of the admin time associated. Then also

1 you probably would need to assess that against his
2 colleagues, how many patients they were seeing at the
3 clinics and how much time they were given so that you
4 were treating every consultant the same. But again,
5 I suppose Mr. O'Brien had his own way of dictating or 15:15
6 not dictating contemporaneously, and Mrs. Corrigan and
7 Mr. Weir were trying to be of assistance to him.
8 230 Q. If we just pick up on one other thread in this meeting,
9 which the Inquiry can look at it in some detail as it
10 wishes. If we scroll on to the issue of MDT. Maybe 15:16
11 just pause there. An issue arose in respect of whether
12 Mr. O'Brien should be given dispensation from taking on
13 any new outpatients. He made the point that he had the
14 most patients waiting to be operated on with the
15 longest waiting list and that it wasn't fair to him to 15:16
16 see new patients and add them to his waiting list, he
17 couldn't deal with him. Mrs. Corrigan clarified that
18 Mr. O'Brien didn't have the most nor the longest
19 waiting times for in and day patients, and the figures
20 are set out there. 15:17
21 Any observations you want to make on that?
22 A. No.
23 231 Q. Moving down, then. In relation to MDT, a question
24 arose as to whether Mr. O'Brien would continue to act
25 in the role of lead for the MDT -- sorry, continue to 15:17
26 act as one of the rotating Chairs of the MDT. He
27 explained there that the demands on him after operating
28 on a Wednesday, to prep for the next day's chairing of
29 an MDT were significant.

1
2 In a follow-up note, Mrs. Corrigan said that she spoke
3 with Mr. Young who felt that if Mr. O'Brien wanted to
4 continue to Chair, then he should drop his theatre
5 session once per month and give it to a locum 15:18
6 consultant and this would allow him to do the
7 preparation for the MDT.
8
9 Can I ask you about this. Was there a requirement for
10 Mr. O'Brien to do additional surgery outwith the 15:19
11 sessions required of him in his job plan?
12 A. There wasn't a requirement. I think again
13 Mrs. Corrigan could talk to this better than I could.
14 He was keen to operate, and any additional operating
15 sessions that were available, he would be keen to take 15:19
16 them up if he could. He also undertook waiting list
17 initiative work, which is outside of core work, out of
18 core job plan time.
19 232 Q. Is there extra remuneration for each of those tasks or
20 each of those? 15:19
21 A. If it's in core time, no. If he is displaced, for
22 example, in SPA or displaced in admin, he wouldn't be
23 paid for that because he's already being paid for it.
24 But if he did waiting list initiative work, he would be
25 paid for that. 15:20
26 233 Q. Isn't it the case that whereas you describe Mr. O'Brien
27 as being keen to operate, and we've seen the additional
28 sessions of theatre work which he did through 2016, it
29 appears to be almost double the sessions expected of

1 him in his job plan. But as well as him being keen,
2 the Service was keen to have him do it; is that fair?
3 A. Yes. Yes.
4 234 Q. Because of the waiting list problems?
5 A. Correct. The length of the waiting lists, yes. 15:20
6 235 Q. Is it also fair to say that Mr. O'Brien was not
7 prevented from doing these additional sessions of
8 theatre notwithstanding the Trust's understanding that
9 he was rarely completing his dictation, rarely
10 completing his triage in the respects we have 15:21
11 discussed?
12 A. So, as I said in March time, that level of analysis or
13 triangulation, that was not done. So, Mrs. Corrigan
14 and Mr. O'Brien had a conversation and Mr. O'Brien was
15 happy to do his operating either in core, however he 15:21
16 was going to do that, then that would have been
17 permitted. It was based on the need to get the waiting
18 list down in a small way. It wouldn't have made a big
19 dint but it was going the right way.
20 236 Q. Here we have in front of us, I suppose, is a 15:22
21 realisation and a practical example of someone saying
22 out loud - perhaps it's novel, it appears to be novel
23 in terms of what we have seen so far in this Inquiry -
24 of Mr. O'Brien's clinical lead, Mr. Young, saying,
25 well, if Mr. O'Brien can't do what's expected of him as 15:22
26 MDM Chair, he should step back from doing theatre and
27 the Trust should instead look to a locum to do it. In
28 a sense that's refreshing, isn't it, we don't see that?
29 A. I agree with you. Mr. Young appears to be saying, you

1 know, we accept that you're under pressure; if you need
2 some time, we can facilitate that time by using the
3 locum to backfill the session, the theatre session that
4 you drop.
5 237 Q. You provided your witness statement to Dr. Chada 15:23
6 following an interview on 6th April 2017. At that
7 interview you raised with her an issue that hadn't
8 occurred or didn't appear to have occurred to anyone
9 before, and that was that Mr. O'Brien wasn't putting
10 the clinical status of his patients onto the form in 15:23
11 association with theatre?
12 A. Yes.
13 238 Q. You drew that to her attention - maybe briefly put it
14 up - in your witness statement, TRU-00765. At
15 paragraph 24 you explain that this issue concerned you 15:24
16 this week.
17
18 "That is when I checked regarding bed pressures,
19 Mr. O'Brien has no clinician priority noted on the
20 theatre list. He said that they are all urgent and 15:24
21 'they will all be done'. We need to be able to
22 prioritise patients when there are bed pressures so
23 we can know who can be cancelled if absolutely
24 necessary. The only person who knows the priority is
25 Mr. O'Brien". 15:25
26
27 Can you help us with that. That's an issue you brought
28 back to Dr. Chada. Subsequently you sent her some
29 documentation around that and then she would have

1 referred that to Dr. Khan, the case manager, for his
2 information. Why is it significant for you?
3 A. Well, I suppose it makes -- let me try to explain.
4 Pre-COVID when patients required operating on, they
5 attended the day surgical unit. If they required an 15:25
6 in-patient stay, they went back to an in-patient ward.
7 At that time in Craigavon it was 3 South, 4 North, 3
8 South. But everybody knows there are more medical
9 patients in the system than we have beds for. It was
10 not uncommon that the surgical wards were used to 15:25
11 accommodate the overflow of medical patients. So not
12 infrequently we would come in in the mornings, thinking
13 we had X amounts of beds to accommodate the
14 post-operative surgical patients only to find out that
15 the beds had been used to facilitate medical patients 15:26
16 admitted overnight.
17
18 What we would do is we would look at the operating
19 theatre list, see what specialists were using the
20 theatres. Then we'd run our eye down to see the type 15:26
21 of -- how the consultant had classified the patient,
22 whether it was cancer, red flag, urgent, routine. So
23 then when we knew what we were dealing with in terms of
24 how many beds we would need, we would go to the
25 consultant and say, you're operating today, 15:26
26 Mr. O'Brien, you've got five patients and four of them
27 are red flag, one is routine, could we cancel the
28 routine patient, and he would say yes or no.
29

1 But Mr. O'Brien didn't put that classification down.
2 It just meant that we didn't know what the -- we could
3 have made a guess, an educated guess in terms of the
4 operational they were having, but it just made it more
5 difficult when you went to the clinician, he would say 15:27
6 to you nine times out of 10, or frequently, what
7 classification did I put against the operation?
8 Mr. O'Brien didn't do that. That's the point I was
9 highlighting. Whereas all the other urologists
10 evidenced how they clinically prioritised the patient. 15:27
11 It was just one small thing.
12 239 Q. A small thing that appears to have irritated you and
13 had an impact on how you wanted to manage your service?
14 A. Well, it just would have been helpful if Mr. O'Brien
15 had been the same as the other four consultants. 15:27
16 240 Q. Did you prevail upon him to change his practice?
17 A. No. Did I pursue it? No.
18 241 Q. I suppose that's the point. We've observed in earlier
19 stages of evidence, operational managers seeking
20 informally to orchestrate change or remedial action in 15:28
21 terms of Mr. O'Brien's practice going back some years,
22 triage being the most prominent example. But nobody
23 actually, until 2016 in all of that, nobody actually
24 sitting down with him, meeting and I suppose making him
25 understand why these rules of practice are important 15:28
26 and requiring him to comply.
27 A. I take your point, yes.
28 242 Q. Nothing had changed by reference to this particular
29 example by the time you came into the role?

1 A. No.
2 243 Q. Why is that? What is the culture that is existent at
3 the time? I suppose you may say this is a relevantly
4 small issue, and I'm sure the Inquiry might accept
5 that, but what is the difficulty that causes you to 15:29
6 fail to sit down with the clinician and say listen, you
7 have to do something different?
8 A. I suppose it's complex. If it was easy, we would fix
9 it.
10 15:29
11 In terms of the life of anybody working in hospitals,
12 there are many, many, many challenges that you face on
13 a daily basis. I suppose everybody is guilty. If the
14 issue isn't sorted there and then, it tends not to be
15 completed, the loop tends not to be completed because 15:30
16 there's something else very quickly falls in behind it.
17 If Mr. O'Brien was the only thing that occupied my
18 life, that would be one thing, but it wasn't. There
19 were many other challenges, not least, you know,
20 Dr. McAllister's state of the nation was only a small 15:30
21 part of the challenges which we faced on a daily basis
22 in the health service.
23
24 Two months of my working life each year was taken up on
25 the role of the Assistant Director of the Week, where 15:30
26 I stopped doing my AD of the week role and I was
27 occupied looking after flow. That was one full week
28 every six weeks. So, if you didn't sort out the
29 problem at source there and then, unfortunately to get

1 back to it, sometimes it never happened because there
2 was just so much more to be done with the resources
3 that we had. Every morning we came in and we were
4 faced with overwhelming patients in ED, trying to find
5 the beds for them. Part of my role in finding the beds 15:31
6 was, well, what surgery can we proceed today with.
7 That is endless and draining. So, plenty of
8 challenges.
9 244 Q. Thank you for that perspective.
10 15:31
11 Now let's move to the monitoring arrangements. You
12 said that while unsighted on the minutes themselves,
13 you did receive an email in relation to this. I think
14 you are copied into this email. Let me bring it up and
15 we'll see. TRU-267575. Scroll up so we can see the 15:32
16 full timestamp. This is Gishkori to Siobhán Hynds, you
17 copied in.
18
19 "Ann McVey has fully briefed Mrs. Gishkori and she has
20 a number of questions. Is there a timescale for the 15:32
21 development of the monitoring process which Ronan and
22 her will assume responsibility for? Is it okay to
23 involve other clinicians in developing this", and she
24 suggests some options around that.
25 15:33
26 Who did develop the monitoring plan?
27 A. Following this email, we met on 6th February, myself,
28 Mrs. Gishkori and Mrs. Hynds, and Mrs. Hynds then made
29 a first draft of it. I think she sent it the next day

1 out for review. I had asked her would she include
2 Mrs. Corrigan in it for her expertise, which she did.
3 There was a few iterations back and forth in a chain of
4 emails. Ultimately then it was shared on 9 February by
5 Mrs. Hynds to ourselves and Dr. Khan and Mr. Weir for 15:34
6 their approval.
7 245 Q. Then there was a meeting that day --
8 A. With Mr. O'Brien.
9 246 Q. -- with Mr. O'Brien. You didn't attend that meeting?
10 A. No, no. 15:34
11 247 Q. Just to observe it, put it up on the screen, please.
12 TRU-00732. Just at the top of the page, please. It
13 remarks in the second paragraph, "Urgent job review
14 plan will be undertaken to consider any workload
15 pressures". How did you interpret that? Was that to 15:35
16 be 'let's work up a new job plan', or was it something
17 like his current responsibilities have to be looked at
18 to ensure appropriate supports are in place?
19 A. Yes. So, he would undertake the full role of a
20 consultant urologist as detailed in his job plan, and 15:35
21 then that would be surrounded by the monitoring plan.
22 248 Q. There's an expectation, it suggests here, of a review?
23 The last sentence in that paragraph.
24 A. Well, I suppose that came out of the 26th Oversight
25 meeting. 15:36
26 249 Q. Yes. What was your understanding of what should be
27 done about that?
28 A. I think Mr. Weir was tasked with that undertaking, that
29 action, so Mr. Weir was supposed to deal with it.

1 I didn't see myself as dealing with it.
2 250 Q. In terms of the monitoring plan itself, obviously - and
3 we'll look briefly at them in a moment - there were
4 flare-ups, if I can put it in those terms, of apparent
5 noncompliance with the job plan in the summer of 2017, 15:36
6 and you attended a meeting in early 2018, autumn of
7 2018, and in late 2019.
8
9 When you think about the monitoring arrangements that
10 were drafted and then put in place, what's your 15:37
11 reflections on how well they worked and how well
12 Mr. O'Brien complied with them?
13 A. As you articulated, there were deviations in the length
14 of time that we had been monitoring Mr. O'Brien. They
15 varied in terms of which aspect of the monitoring plan 15:37
16 Mr. O'Brien fell down in. But were they effective?
17 I would say not, in that there were deviations over
18 that four-year period, three to four-year period. But
19 did we sit down again and say, look, this monitoring
20 plan needs to be reviewed, this monitoring plan is not 15:38
21 fit for purpose? That wasn't done.
22 251 Q. Obviously the mischief which the monitoring plan served
23 to address was the question of can exclusion be
24 avoided, can Mr. O'Brien be brought back to work and
25 enabled to work his job plan in a way which the Trust 15:38
26 considers to be safe. From that perspective, did the
27 monitoring arrangements allow yourself and
28 Mrs. Corrigan to have confidence that things were going
29 in a relatively safe direction?

1 A. Yes, I think that would be fair to say. I think in the
2 length of time -- and I would say we monitored him far
3 too long, but in the length of time we did monitor him
4 Mr. O'Brien, for those aspects that we were monitoring,
5 largely they were kept in check. So yes, I would 15:39
6 say -- and where there was deviations, bar the one
7 in October, on October 18th, they were picked up
8 relevantly quickly and dealt with and escalated to the
9 case manager.
10 252 Q. You say he was monitored far too long. What do you 15:39
11 mean by that?
12 A. Well, I suppose to have anybody on a monitoring plan
13 from 2017 until you retire in June 2020 - although
14 we stopped monitoring him when COVID hit in around
15 March of 2020 - it has never been my experience that 15:40
16 you monitor them essentially for three years, you know,
17 and you are monitoring the same thing all the time.
18
19 Again, with hindsight and 20/20 vision, I think we
20 should have brought the Oversight Committee meeting 15:40
21 back, we should have met more regularly. There should
22 have been greater oversight from the Oversight
23 Committee in terms of, you know, what position we were
24 at six months in, 12 months in. I know the parallel
25 process was going on in terms of Dr. Chada and 15:40
26 Dr. Khan, but I can't help but think, sitting here now,
27 it may have been helpful and we could have brought
28 about another way of monitoring Mr. O'Brien. I don't
29 know what that was but I think to monitor someone, just

1 simply monitoring someone for three years can't be seen
2 as a success.
3 253 Q. What were the aspects of it? You say we didn't meet to
4 review the arrangements at any point. Thinking about
5 how it did work in practice, what are your thoughts on 15:41
6 it? If you had been given the tools to change it or
7 revise it in any way, what would you have introduced?
8 A. Well, I suppose the first thing - and you've made
9 reference consistently today to it - we didn't
10 communicate with Mr. O'Brien. That's the first thing. 15:41
11 This was consistently poor. We should have. I think
12 there should have been, particularly after the 26th
13 meeting, again there should have been oversight as to
14 have all those actions been completed; and that wasn't
15 done. Then I suppose just in terms of meeting with 15:42
16 Mr. O'Brien, see how he was getting on. Then continue
17 to monitor those aspects that we felt still remained
18 clinically important. Also asking him, you know, his
19 concerns, his stresses, his worries and what we could
20 do as an employer to help along that. We didn't do any 15:42
21 of that.
22 254 Q. I don't intend to take you to -- in the interests of
23 time --
24 A. That's just my reflection.
25 255 Q. Yes, and that's very helpful. 15:42
26
27 You say you didn't meet with Mr. O'Brien. Of course,
28 I know that's a general observation, there were
29 meetings with him along the timeline that I've just

1 sketched out. There was a meeting with him, for
2 example, in July 2017. In the early summer of 2017,
3 issues were identified by Mrs. Corrigan in respect of
4 retention of charts in his office which seemed to build
5 up to 90 on 11th July 2017. Then, at or about the same 15:43
6 time, a problem with triage. If we can just, by way of
7 example, look at that interaction. TRU-25877. That is
8 not what --
9 CHAIR: 8877, perhaps? TRU-258877.
10 MR. WOLFE KC: That's it. Thank you. 15:44
11 Down the page, please.
12
13 Obviously you are copied in, Mr. Carroll. That is the
14 July. It sets out for Mr. O'Brien the condition of his
15 work plan, including that red flag referrals must be 15:44
16 completed daily.
17
18 Scroll down, please.
19
20 "He has been advised by the booking centre that there 15:45
21 are 30 paper outpatient referrals not returned from
22 your week on-call and this must be addressed urgently,
23 please".
24
25 Then let's go to Mr. O'Brien's response. TRU-268995. 15:45
26 Scroll down. Just pause a moment. Sorry.
27 CHAIR: Might it still be the original page of 258877?
28 MR. WOLFE KC: I beg your pardon, AOB-01646. Another
29 malfunction. Yes, sorry, it is right at the bottom of

1 that page. Hiding at the bottom.
2
3 Mr. O'Brien has just read Mrs. Corrigan's email in
4 respect of the paper triage that hadn't been returned,
5 and he tells her he finds this demoralising and 15:47
6 provides an explanation. Scroll down, please. He says
7 that he's deferred returning these referrals as each
8 day's bundle included patients who needed to be
9 contacted so that the appropriate triage decision could
10 be made. He says that's proved difficult for a number 15:47
11 of reasons. He gives an example.
12
13 "One such was a female patient who has a stone in her
14 ureter, who returned my calls this morning to say she
15 was in pain, which I had expected her to be. I had 15:48
16 returned her triage referral to have an urgent
17 appointment at a new clinic whenever that would have
18 happened. However, I have arranged her admission today
19 for that procedure on the emergency list. By virtue of
20 the returned referrals not having been collected today, 15:48
21 12th July, I have been able to amend the triage
22 decision. I came into the hospital today to review a
23 couple of patients admitted since the referrals.
24 Having done so, I thought I would do some work in my
25 office, then I read your emails". 15:48
26
27 He then says:
28
29 "I know how referrals are triaged and returned on time.

1 It is most certainly not by taking the time to ensure
2 that each patient's current state is most appropriately
3 and expeditiously assessed and managed. As a
4 consequence of my doing so, I have dictated letters to
5 the referring doctors, and to the patients if I have 15:49
6 been unable to speak to them by telephone, in over
7 50 cases, requesting scans, having conditions treated
8 appropriately and so forth. By doing so, investigation
9 is progressing and patients are hopefully deriving
10 benefit from treatment. Having done all of that, 15:49
11 I personally would have been better off ticking the
12 box, being at home on my leave, and the patient, she
13 would be at home with persistent colic, awaiting the
14 urgent outpatient point."
15 15:49
16 What you see there, and I know you are not copied in
17 this email, but from Mr. O'Brien's perspective, he is
18 saying in this email there has to be some trade-off or
19 accommodation to enable him in appropriate cases to do
20 adequate triage to deal with the patient's real needs, 15:50
21 even if that is at the expense of him devoting extra
22 time and, I suppose, consequentially triage being done
23 outside of the time limits expected by the
24 return-to-work monitoring plan.
25 15:50
26 Is that a refrain that you understand?
27 A. You're right, I wasn't copied into it. I suppose my
28 take on it is a sense of frustration from Mr. O'Brien.
29 I mean, this type of triage, I don't know what term you

1 would apply to it other than maybe super triage. It is
2 almost like an outpatient appointment. I think
3 Mr. Haynes referred to it as a virtual outpatient
4 undertaken by Mr. O'Brien. Whilst for the patient,
5 it's an excellent service, there are other patients on 15:51
6 Mr. O'Brien's waiting list who may not get the same
7 level of advantage triage. I don't know, I'm just
8 surmising.
9
10 I suppose I would also say, Mr. Wolfe, that he was met 15:51
11 with by Dr. Khan on 9th February and the monitoring
12 plan was shared with him, and I'm guessing he agreed or
13 accepted in principle that he was now on a monitoring
14 plan which required him to comply with that. Here we
15 have, you know, several months down the road and he's 15:51
16 slipping back into bad habits -- well, slipping back
17 into his previous practice.
18
19 I can understand his frustration because that's the way
20 he always done it but I don't know if he appreciated 15:52
21 this was a new world he was operating in. He still
22 wanted it to be the old world. That would be my take
23 on it.
24 256 Q. Just to move along. In July you attended with
25 Mr. Weir. The issue at this stage, the issues around 15:52
26 triage having resolved during that period of time, was
27 the question of charts in his office. This is, as
28 I understand it, the first meeting with Mr. O'Brien to
29 discuss a deviation from his work plan?

1 A. That's correct.
2 257 Q. Is that your understanding of the meeting?
3 A. Yes, that's correct.
4 258 Q. It's not a meeting that was recorded by you or anyone
5 else from the Trust. Mr. O'Brien has surreptitiously 15:53
6 recorded it, and we have the transcript from that.
7 Why, in circumstances where this monitoring arrangement
8 is supposed to be a serious effort to avoid excluding
9 Mr. O'Brien and when serious issues are referred to
10 within it, why is this meeting not granted the 15:53
11 formality of a record?
12 A. It absolutely should have. The purpose of the meeting
13 was to understand why the volume of notes were in his
14 office, and if we understood, we could help. But yes,
15 absolutely a record should have been made of the 15:53
16 meeting, and that shared with Mr. O'Brien.
17 259 Q. He said at the meeting -- very briefly, if we can pull
18 up AOB-56212, which is the transcript that's produced
19 from the recordings. Essentially in that paragraph
20 just below B, he's saying I don't ask for these charts, 15:54
21 they are brought to my office by the secretarial teams,
22 and while the numbers are decreasing as of last Friday,
23 the number is still 25. But the rule is, according to
24 the return-to-work monitoring plan, charts are not to
25 be stored in his office, they're to be kept for the 15:55
26 minimum period feasible.
27
28 This explanation that he has given to you, is that
29 tested by you? Is it something to do with secretarial

1 preference or convenience?
2 A. Was it tested by me, no. When Mr. O'Brien provided
3 this explanation, I think Mr. Weir replies, well,
4 that's good, we'll get the notes and you have no need
5 to get the notes. I think Mrs. Corrigan says that 15:55
6 she would communicate with the service administrator,
7 Marie Evans, in regard to the notes and the need for
8 the notes to be there.
9 260 Q. 2017, the issue of triage arises again. TRU-275137.
10 Martina is writing to Siobhán Hynds. She's explaining 15:56
11 that red-flag triage was to be done within 24 hours and
12 all other triage by the Friday. She, that is Martina
13 Corrigan, has agreed with you that she is going to meet
14 Mr. O'Brien to discuss this with him. This is,
15 I suppose, the second incident of -- 15:56
16 A. Deviation.
17 261 Q. -- deviation from triage, at least as perceived by the
18 Service in a little over six or seven months.
19
20 Do you think, looking back on it, knowing what 15:57
21 Mr. O'Brien is saying about how he is still doing
22 triage - you call it super triage or virtual
23 outpatients - do you think that issue wasn't well
24 understood or well responded to by you and
25 Mrs. Corrigan to try and nip it in the bud? 15:57
26 A. So, this incident was highlighted by the cancer team,
27 which we would not be monitoring as part of
28 Mr. O'Brien's four elements. This was a separate
29 team --

1 262 Q. I understand.
2 A. -- who were alerting Mrs. -- I think the email came to
3 the urology team, there were seven red flags
4 outstanding, and then it worked its way down to
5 ourselves. It was resolved within a very short period 15:58
6 of time. Within days it was fixed. I had asked
7 Martina to share it with Siobhan - I think it was the
8 end of January the red flags came - again, so that they
9 were aware. In my mind my role and Mrs. Corrigan's
10 role was to be the monitors of the action plan and 15:58
11 then, where there was a deviation, to escalate that up
12 to the manager and HR. So, that's why I asked Martina
13 to share it with Siobhán, Mrs. Hynds.
14 263 Q. Is the sense to be gained from your evidence that
15 overall - and we will come to some of the incidents 15:59
16 later in 2018 in a moment - these instances are
17 short-lived, they are identified, which is important
18 from a safety issue, and when Mr. O'Brien is challenged
19 or addressed in respect of them, they are resolved in a
20 relevantly speedy fashion? 15:59
21 A. Yes, yes. So all the deviations, 17 and 18 and 19,
22 they were resolved within a short period of time.
23 264 Q. In termination of accuracy, can I just bring one issue
24 up with you? TRU-258902. Martina Corrigan is
25 communicating with Siobhán Hynds, copying you in. 16:00
26 We see in the Chada report reference to Mr. O'Brien,
27 I suppose I think the word was "robustly" complying
28 with the action plan. I draw a link between this email
29 and the content of Dr. Chada's report in that respect

1 because what is being described here is:
2
3 "Apart from one deviation on 1st February when
4 Mr. O'Brien had to be spoken to regarding red-flag
5 triage, which he immediately addressed, I confirm he 16:00
6 has adhered to his back-to-work action plan, which
7 I monitor on a weekly basis".
8
9 Of course that's leaving out of account, to be
10 absolutely accurate about it, the events of the summer 16:01
11 of 2017, when we saw there was deviations in respect of
12 referrals and you had to meet with him to discuss
13 storage of charts in his office.
14 A. I accept that, that Martina's return is inaccurate in
15 that since the monitoring started in February 2017, 16:01
16 there had been two deviations, one in the summer of '17
17 and this one in February of '18.
18 265 Q. Is my point in respect of that pedantic in your view,
19 or is this --
20 A. No, no. No, no. No, I think it's a fair point. 16:01
21 266 Q. But does this reflect perhaps - we can obviously ask
22 Mrs. Corrigan about it - does this reflect perhaps a
23 sense on the part of you and that team that things are
24 going along relatively well in this respect?
25 A. I think you probably need to ask Mrs. Corrigan in terms 16:02
26 of what her thought processes were. Maybe she misread
27 it, I don't know. I suppose I would say in fairness to
28 Mrs. Corrigan and myself, the July 2017 and
29 the February 2018 were escalated to Dr. Khan and

1 Mrs. Hynds. They were aware that there were two
2 deviations because we'd escalated them to them.
3 267 Q. You said earlier that you thought it was, in a sense,
4 regrettable that this monitoring plan continued for so
5 long right through into 2020. You know now, and 16:02
6 I wonder did you know in late 2018, that Dr. Khan's
7 determination following the MHPS investigation was that
8 there should be, with NCAS input, a further action plan
9 developed to ensure that Mr. O'Brien continued to work
10 safely. Did you appreciate that at the time? 16:03
11 A. No. I was not aware of Dr. Khan's -- the outcome of
12 Dr. Khan's recommendations in 2018. I didn't get to
13 see them until much later.
14 268 Q. In terms of what was happening in the summer of 2018
15 which affected the monitoring plan, Mrs. Corrigan was 16:03
16 off work for some time; isn't that right?
17 A. Correct.
18 269 Q. By the 4th October, it was drawn to your attention that
19 Mr. O'Brien was not compliant with the monitoring
20 arrangements. 16:04
21 A. That's correct.
22 270 Q. In that respect, concern was drawn to your attention
23 about dictation and triage?
24 A. Dictation and notes.
25 271 Q. That's right, sorry. I'm just checking my note. Notes 16:04
26 being held in his office and dictation.
27
28 The incident, if I call it that, generated quite a lot
29 of correspondence. In summary, this was a situation

1 where, with Mrs. Corrigan going off on leave, there had
2 been a failure on the part of the Service to recognise
3 the gap created by her absence in terms of the need to
4 monitor Mr. O'Brien; isn't that right?
5 A. That's correct. 16:05
6 272 Q. Do you accept responsibility for failing to fill that
7 gap?
8 A. Yes.
9 273 Q. In terms of what emerged from that, we know that
10 Dr. Khan wrote to Mr. O'Brien in October to ask him was 16:05
11 he adherent to the monitoring plan, but it doesn't
12 appear that anybody at that time met with Mr. O'Brien
13 to reinforce the need for compliance. Is that fair?
14 A. Again, that's fair. Yes.
15 274 Q. Now, these events were happening as the determination 16:06
16 from the MHPS process was being published, if you like,
17 as Dr. Khan reached his conclusions.
18
19 The monitoring provides, in the preamble if you like,
20 that it would be in place for the duration of the 16:06
21 formal investigation. Again, leaving aside
22 Mrs. Corrigan's absence and what happened in relation
23 to that, did you have a sense that it was felt that
24 this monitoring plan had served its purpose and was no
25 longer live, or did you understand that it remained in 16:07
26 place?
27 A. Do you know, I think in my Section 21 I said that
28 I understood from, as you say, the preamble, that it
29 would remain in place until the completion of the MHPS

1 process. I think in 2018 I did ask Dr. Khan was it to
2 continue and he came back firmly and said yes, it was
3 to continue. So I abided -- we complied with that.
4 275 Q. In terms of your own responsibility for ensuring that
5 it was monitored during Mrs. Corrigan's absence, how do 16:08
6 you explain the failure, I suppose, to deal with that?
7 A. Mrs. Corrigan went off on sick leave for a planned
8 operation, and her and I discussed it. She was advised
9 by her consultant that she would be off six to eight
10 weeks, give or take. In terms of getting a replacement 16:08
11 in, if you've ever tried to make an appointment in the
12 Health Service, it takes much longer than six weeks to
13 get someone in post. So, there was no opportunity to
14 bring in someone to backfill her post.
15 16:08
16 I suppose two things: Mindful of keeping it within a
17 small set of staff who knew the full totality of what
18 was happening with Mr. O'Brien's monitoring exercise,
19 I did ask the two other heads of service would they
20 keep an eye on Martina's work. But I didn't ask them 16:09
21 to continue on the monitoring exercise because in my
22 head, Martina was coming back in six to eight weeks.
23 Then genuinely it was -- and I suppose I was also
24 mindful that Mr. O'Brien, bar the escalation from the
25 red flag team in February, Mr. O'Brien had been 16:09
26 compliant for over a year. That was also in my mind.
27
28 But when Martina's eight weeks became 18 weeks, it
29 just -- I had forgotten about it is the only

1 explanation I can give. It was forgotten about in just
2 the activity of working, of work.
3 276 Q. We can see that Dr. Khan, when he becomes appraised of
4 this issue, describes this as unacceptable practice by
5 both the clinician, Mr. O'Brien, and responsible 16:10
6 managers. In Mr. O'Brien's case, the information as of
7 4th October was that he had 74 sets of notes in his
8 office and 91 letters undictated dating from 15th June
9 2018.
10 16:10
11 If it was unacceptable practice on his part, that's
12 Mr. O'Brien's part, can you explain why no one saw fit
13 to meet with him to reinforce the need for compliance?
14 There had been a meeting in July 2017, as we saw. It
15 was to discuss the issue of notes in his office. Here 16:11
16 was, I suppose, a more serious issue, perhaps, because
17 it involved the issue of dictation.
18 A. Well, I did ask for the assistance of my senior medical
19 colleagues, could Mr. O'Brien be spoken to.
20 277 Q. That's Mr. Young, Mr. Haynes and Mr. Weir? 16:11
21 A. Yes. Then Mr. Weir wrote to Dr. Khan saying what is it
22 you want me to do; I'm happy to go with Ronan to speak
23 to him. But the meeting never happened.
24 278 Q. Can you explain why?
25 A. I don't know why the meeting -- I can't explain why the 16:12
26 meeting didn't take place. I think we were busy trying
27 to bring particularly the dictation back into line.
28 That was our focus. Which we did in a short period of
29 time.

1 279 Q. Turn briefly to 2019 then. TRU-279848. Just at the
2 bottom of the page, please.
3
4 Yes. 16th September, Martina Corrigan's writing to
5 Dr. Khan. We're into late 2019. By this stage, as 16:13
6 we know, MHPS has reported the year before, Mr. O'Brien
7 continues to be monitored. Here again, we have
8 Mrs. Corrigan spotting a difficulty. It doesn't appear
9 that you are copied into emails by this stage?
10 A. Yes. I seem to be excluded out of quite a number. 16:13
11 280 Q. Yes. Is that because there had been some kind of step
12 change in how monitoring was to be regarded, or had you
13 fallen out with Mrs. Corrigan?
14 A. No, no. The only explanation is I wasn't in the first
15 one and then reply-to-all, I'm not in the subsequent 16:14
16 ones. That's what I'm thinking.
17 281 Q. Again, do you have a knowledge nevertheless of this --
18 A. Yes. I mean, I subsequently -- I'm sure Mrs. Corrigan
19 then did share this with me or discuss it with me. My
20 understanding for this deviation in September 2019, and 16:14
21 it was acknowledged by Mr. Haynes, was that
22 Mr. O'Brien's mother-in-law passed away in around this
23 time, and he was preoccupied -- him and his wife were
24 preoccupied by caring for Mrs. O'Brien's mother, and
25 that was the reason for this deviation. 16:14
26 282 Q. Nevertheless, it was regarded as something that
27 necessitated a meeting between the new clinical
28 director, Mr. McNaboe, and Mr. O'Brien. You were aware
29 of that?

1 A. Again, I'm aware of it now. In terms of real-time back
2 then, I wasn't aware of it, that Mrs. Corrigan was
3 meeting with Mr. McNaboe. I also know that the
4 meeting didn't happen.
5 283 Q. Yes. I think there's two views on that, but certainly 16:15
6 I think from Mr. McNaboe's view there was an encounter
7 in a corridor as opposed to a formal meeting.
8
9 By this time there was discussion about the process of
10 monitoring dictation used by the Trust. That was to 16:15
11 give rise to a meeting at the direction of the Medical
12 Director in January, the New Year, 2020. As we can see
13 WIT-55822. You were in attendance at this meeting on
14 24th January. The purpose of the meeting is set out
15 here. What's your reflections on that meeting, 16:16
16 Mr. Carroll? It seems to arrive at a conclusion that
17 the Trust's policy, if it had one, and its processes
18 around dictation were not sufficiently fit to permit
19 any challenge to Mr. O'Brien in terms of his compliance
20 with the monitoring arrangements in that respect. Is 16:17
21 that a fair comment?
22 A. Yes, yes. I mean, I think I read an email in the
23 evidence bundle between Dr. O'Kane and Mr. Haynes in
24 early November where Mr. Haynes is describing his
25 concern about the whole backlog report to Dr. O'Kane, 16:17
26 and about the robustness of it, and the fairness of it
27 in terms of holding Mr. O'Brien to account to a certain
28 standard and not holding any other consultant to the
29 same standard, and basically we don't have a standard.

1 I think that may have helped - again, I'm only
2 surmising - may have helped why Dr. O'Kane wanted this
3 to be resolved. I could be entirely wrong.
4 284 Q. But a standard, whether it was inconsistent with what
5 was expected of others, a standard had been arrived at 16:18
6 for Mr. O'Brien, hadn't it? That was set in stone in
7 the monitoring plan from February 2017, dictate
8 contemporaneously with your clinical encounter. So,
9 why was there this degree of --
10 A. Concern? 16:18
11 285 Q. -- internal concern or deliberation about something
12 that had been made clear to Mr. O'Brien and he wasn't
13 always compliant with?
14 A. I think again - again, this is just my view -
15 Mr. Haynes always shared or harboured concern about the 16:19
16 robustness of the monitoring. There were emails in
17 2017 and 2019 and so forth, where he had written to the
18 RBC asking how it was done, etcetera, etcetera.
19 I think it was his concern - again I'm just repeating
20 myself - in terms of the backlog report and the 16:19
21 monitoring of the backlog report and compliance with
22 dictation if there was no standard available. Again,
23 I could be entirely wrong, I just think Mr. Haynes felt
24 it was unfair to hold Mr. O'Brien to a standard
25 that didn't exist except... 16:19
26
27 Obviously in the cold light of day and with retrospect,
28 a standard for Mr. O'Brien had been set in terms of the
29 issues which we now know, in terms of his dictation,

1 his contemporaneous dictation and relating that to
2 Patient Safety. But again, that wasn't connected --
3 the dots weren't connected to the monitoring report in
4 2017 and this meeting in 2020.
5 286 Q. Yes. One further area of questions for you, 16:20
6 Mr. Carroll, you'll be pleased to know. The MHPS
7 determination resolved that there should be an
8 independent review of administrative processes. I want
9 to ask you about that. If we could have up on the
10 screen, please, AOB-01923. Just scrolling down the 16:20
11 page, please. Under Final Conclusions/Recommendations,
12 it said that:
13
14 "The investigation highlights issues regarding systemic
15 failures by managers at all levels, both clinical and 16:21
16 operational, within the Acute Services directorate.
17 The report identifies that there were missed
18 opportunities by managers to fully assess and address
19 the deficiencies in practice of Mr. O'Brien. No one
20 formally assessed the extent of the issues or properly 16:21
21 identified the potential risks to patients".
22
23 Is that a conclusion with which you agree?
24 A. Yes. I don't think that's unfair.
25 287 Q. Arising out of that and what he says there at the 16:21
26 bottom of the page, he says:
27
28 "I recommended the Trust carry out an independent
29 review of the relevant administrative processes with

1 clarity on roles and responsibilities at all levels
2 within the Acute Directorate and appropriate escalation
3 processes".
4
5 Now, we know that recommendation had not been addressed 16:22
6 by 2020 and then there was, I suppose, a flurry of
7 activity in the summer of that year to get the process
8 moving. When did you first become aware of this
9 recommendation?
10 A. It certainly was in 2020. Maybe early 2020. 16:22
11 288 Q. In terms of your contribution to it, can you help us
12 understand what role you played in the review?
13 A. It was towards the latter end of probably 2021. This
14 recommendation was picked up by Dr. O'Kane in terms of
15 progressing it forward. Dr. Donnelly and 16:23
16 Dr. McCullough were asked to take this forward and to
17 draft a model or a proposal which would meet this
18 recommendation. So, I have to say what was done by
19 Dr. McCullough and Dr. Donnelly, and subsequently by
20 everybody else, did not, in my view - I haven't 16:23
21 listened to Dr. Khan - did not capture the essence of
22 what Dr. Khan wanted to happen, even though despite
23 many eyes and many fingers over it.
24 289 Q. We can see, just to bring it up, an email of
25 25th October 2021, pressing your input into it. 16:24
26 TRU-293812. Martina Corrigan is telling Siobhán Hynds
27 that:
28
29 "As discussed at our last urology Oversight meeting,

1 Ronan and I have revised the administrative review
2 process to anonymise/make it more generic to all
3 areas".
4
5 What had brought this review to a stage where the 16:25
6 managers, and you were one of them, who perhaps
7 Dr. Khan thought your activities should be the subject
8 of this review, looking back at what had happened in
9 the context of Mr. O'Brien's work. What had brought
10 this to a situation where an independent review, 16:25
11 so-called independent review or requirement for an
12 independent review, allowed you to be, on the face of
13 it, contributing to it in this way?
14 A. So, nowhere in my thought processes or indeed anybody
15 involved in this processes other than Dr. Khan viewed 16:26
16 his recommendation as what he had intended. I suppose
17 it wasn't helped where he used the word
18 "administrative" and the whole way along we had
19 referred to Mr. O'Brien's practices as administrative
20 practices. So, I think there was an association 16:26
21 between what Dr. Khan was writing in his recommendation
22 to the history of Mr. O'Brien's administrative
23 practices, and those were put together. Because the
24 work done by Dr. Donnelly and Dr. McCullough was one of
25 administration process, referrals in, how they were 16:26
26 managed, etcetera, etcetera. And then that was viewed
27 to be not a robust piece of work. Then it was
28 assigned, I think, Steven Wallace. So I suppose it
29 went from being Dr. Khan's macro written branch review

1 of administration in acute services, it had become a
2 very micro specific urology review service.
3 I understand Dr. Khan signed off on. I could be wrong
4 on that.
5 290 Q. I think he challenges that. 16:27
6 A. Okay.
7 291 Q. He gave certain observations in respect of the terms of
8 the reference and clearly set out his view that
9 he didn't accept that. Leaving that aside --
10 A. Okay, leaving that aside. 16:27
11 292 Q. -- I suppose the question is did this, as it was
12 produced, satisfy the review of independence?
13 A. No. I suppose did it satisfy Dr. Khan's review that he
14 had in his mind when he wrote the recommendations, no,
15 clearly not. Because was it independent? The Trust 16:27
16 did obtain independent input from a member of the
17 senior administrative staff in the Belfast Trust,
18 Denise Lynne in regard to the administrative processes,
19 not the, I suppose, root and branch disciplinary review
20 of senior managers. But the four aspects of 16:28
21 Mr. O'Brien's administrative practices, it was
22 independent advice from Denise Lynne; she helped shape
23 it. Then Martina was asked to progress with it and
24 I helped her with it. But never in my contemplation
25 could I read Dr. Khan's recommendation as one of 16:28
26 discipline, if that's not too strong a word.
27 293 Q. Yes. He doesn't use that word. He has explained
28 himself what he anticipated would be done.
29

1 Who was leading on this from the Trust perspective, in
2 your view?
3 A. It started off with Dr. O'Kane. Then, when it became
4 under the work of Mr. Wallace, then it migrated into
5 Acute Services and Mrs. McClements was involved in it 16:29
6 and Mrs. Corrigan and Mrs. Carroll, and the referring
7 booking centre also tried input into it and shaped it.
8 I suppose at that stage the referring booking centre
9 was part of Acute Services. When it became a micro
10 urology issue, I suppose it was taken on by 16:29
11 Acute Services, and not independent.
12 MR. WOLFE KC: Thank you. I have no further questions
13 for you, Mr. Carroll.
14 CHAIR: Mr. Carroll, we can't release you just yet. I
15 appreciate we haven't had a break this afternoon, 16:30
16 ladies and gentlemen, but if you can bear with us, I'd
17 rather we just continued on and get finished. I think
18 if anyone does need to leave the room, then please do
19 so, but I'm going to ask Dr. Swart, first of all, for
20 some questions. 16:30
21
22 THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL
23 AS FOLLOWS:
24
25 DR. SWART: Thank you very much for bearing with us 16:30
26 today. These are general questions really based on
27 your experience as a manager in the Trust.
28
29

1 Just to start with, in your role as Assistant Director
2 did you get any regular reports that provided any kind
3 of range of metrics about the performance of
4 outpatients generally? So I'm thinking about time to
5 first appointment, time to follow-up, dictation times, 16:31
6 workload by consultant, complaints, patient feedback.
7 Was that ever pulled together so that you could look at
8 it by speciality and see what was going on?
9 A. I suppose the short answer is no. That level of detail
10 we didn't -- was not provided. 16:31
11 294 Q. Would that have been helpful?
12 A. Absolutely, yes.
13 295 Q. A general question about private patients. Now, you
14 have said that there is a form, which we have seen,
15 that requires a consultant to indicate when a patient 16:31
16 is transferred from private status to NHS status. You
17 haven't said this but you've implied that perhaps isn't
18 always done and you certainly don't know what happens
19 to the forms. I think you said that.
20 16:31
21 Are you aware of any Trust guidance on the transfer of
22 patients to and from the private sector? In other
23 words, a patient who is seen in the private sector
24 transferred to the NHS for an operation or a test, then
25 seen again in the private sector. Is that common 16:32
26 practice at the Southern Trust, do you know?
27 A. Some years ago the Trust made the decision not to offer
28 operating time to private patients because it was so
29 complex, it couldn't be tracked, a lot of purposes,

1 etcetera.
2
3 I suppose to answer your question, the Department of
4 Health before - it could be six months ago, could be a
5 year ago - they issued recent guidance on how private 16:32
6 patients should be treated moving in and out of the
7 Health Service. That is now available.
8 296 Q. Is that enforced in the Trust?
9 A. Sorry?
10 297 Q. Is it enforced or was it, in 2016, quite common for 16:32
11 people to transfer back and forth?
12 A. I would say it was uncommon. We're not a big hospital
13 for private patients.
14 298 Q. Okay.
15 16:33
16 There's very detailed monitoring arranged for
17 Mr. O'Brien, and the standards are quite specific.
18 Were there standards applied to the other consultants
19 in urology in any way, or did you receive any data
20 concerning things like numbers of notes in offices, 16:33
21 numbers of notes at home, dictation times, any of those
22 things?
23 A. Did we actively monitor the other consultants in that
24 respect, the answer is no.
25 299 Q. You were, in effect, applying a standard to him that 16:33
26 you couldn't apply to the other consultants?
27 A. It's not that we couldn't, we didn't because they
28 weren't the source of the review. I suppose, if
29 there's any consolation, in October of 2018,

1 Mrs. Corrigan, when she was reported an update of the
2 amount of notes in the offices, she reported that there
3 was zero notes in the offices of the other four
4 consultants.
5 300 Q. With the benefit of hindsight, what is your view on 16:34
6 this in terms of monitoring one individual in this way?
7 A. Well, as I said, I thought the monitoring was far, far
8 too long. People were exhausted. I'm sure Mr. O'Brien
9 was exhausted. But people were exhausted doing it.
10 301 Q. No, in terms of fairness, I mean. 16:34
11 A. Is it fair to have someone on a monitoring action plan
12 for three years? No, I think it's unfair. As I said,
13 I think the Trust should have - and I'm part of the
14 Trust - we should have sat down and consciously at set
15 points thought and revised and updated ourselves as to 16:34
16 have we reached a threshold for which we could stand it
17 down.
18 302 Q. Was any of the data that you were looking at obtainable
19 automatically in some way. This required conscious
20 monitoring but it would be much easier if your business 16:35
21 objects and other systems could just generate this
22 information for all consultants, actually.
23 A. I'm no expert in business objects but I'm sure it can
24 be done. Digital dictation can be, I understand, run
25 through a report. Triage also. But yes, our ability 16:35
26 to audit is very poor, in my view, and we need to
27 strengthen that. We have processes in place, but do
28 we audit them regularly to provide assurance? I think
29 the answer to that, to be fair, would be no.

1 303 Q. That's kind of what I'm getting at.
2
3 If you were talking to a layperson, say you were at a
4 dinner party and someone said, look, there are very
5 long waiting lists for everything in Northern Ireland, 16:36
6 and particularly long waiting lists in the Southern
7 Heath care Trust. Say someone asked you that, what
8 would you say about what the Trust is doing to minimise
9 the chance of harms to patients or in fact to assess
10 whether patients are coming to harm? How would you 16:36
11 explain that to the man in the street?
12 A. What I will say is that in terms of triage, we now have
13 E triage so that the referral now won't be lost; it's
14 not paper and can monitor that. I would say that in
15 terms of your outpatient point, if and when you are 16:36
16 seen by the consultant, we have made great inroads in
17 our interactions, our contracts with the independent
18 sector. We are sending large volumes of patients out
19 to the independent sector. New patients. They stay
20 out there for the whole patient journey as appropriate. 16:37
21 We have made significant roads in reducing the waiting
22 volume. I don't know what they are now but we had made
23 significant volumes.
24
25 I suppose we could always do more in terms of educating 16:37
26 GPS in terms of the referral pattern, identifying GPs
27 which are high referrers and understanding why that is,
28 etcetera, etcetera.
29 304 Q. How do you ensure that people on these waiting lifts

1 aren't coming to harm? Do you have a way of assessing
2 that?
3 A. No, we don't.
4 DR. SWART: That's all from me.
5 CHAIR: Mr. Hanbury. 16:37
6 MR. HANBURY: Thank you. Just a few clinical things.
7 Thank you very much for your evidence today.
8
9 I'll try the MHPS, the dictation ones first. Just to
10 clarify, the original 668 patients alleged not to have 16:37
11 letters, did I understand that you said that that
12 number came down to 189 in the end? Did you agree with
13 Mr. O'Brien's assessment?
14 A. I haven't looked in much detail at what Mr. O'Brien has
15 said so I wouldn't be in a position to say I agree with 16:38
16 it or not.
17 305 Q. Okay, thank you. Also, when the urologist went through
18 those undictated patients and identified 35 needed to
19 go on the waiting list, were they disadvantaged, do you
20 think? 16:38
21 A. No.
22 306 Q. How were they not disadvantaged?
23 A. Because we put them on -- we put the patient on to the
24 waiting time that they should have been put on. But
25 our waiting times are so huge, the patients would not 16:38
26 have missed their slot, would not have missed their
27 operating time.
28 307 Q. On the same theme, going back into the early part of
29 the witness statement and looking at capacity for

1 operating time which Mr. O'Brien and his colleagues
2 wrote to you about. You used a phrase when discussing
3 expansion, you said "The physical theatre capacity
4 would not be able to accommodate more sessions". When
5 you were thinking about more urologists and whether 16:39
6 that would help, how would having more surgeons help if
7 you didn't expand the theatres?
8 A. Well, they could have done -- I suppose I was thinking
9 two things. We have a huge emergency surgery. So, you
10 know, they could help -- if we had more surgeons, they 16:39
11 could help with the emergency side of the work because
12 still there's always an emergency theatre.
13
14 We had a urology ward which had unscheduled urology
15 patients, so having more consultants would help with 16:39
16 that. They could also help with the outpatient work,
17 and also they could help backfill. If we have five
18 consultants, they're all taking leave, the additional
19 person could use, for example, Mr. Haynes' operating
20 list, Mr. O'Brien's operating list, Mr. Glackin's 16:40
21 outpatient list if he's on leave. So, there was never
22 any downtime in the urology because, as you know, each
23 consultant works his job plan for 42 weeks, when
24 you take out the emergency work, they actually only
25 provide elective work 36 weeks. If we had more 16:40
26 consultants, then we could have used the theatres more
27 productively.
28
29

1 We did try extending the day, so a three-session day,
2 but that has problems. Consultants didn't like it,
3 people got tired, and the utilisation of the list went
4 down.
5 308 Q. Thank you. 16:41
6
7 There was also something about the discrepancy between
8 different departments in terms of waiting times. Did
9 you sort of allocate sessions to the more needy
10 departments? How did you respond to those sort of 16:41
11 figures? That is if, say, urology had a longer waiting
12 time and other specialties a shorter one, was there a
13 mechanism to reallocate either temporarily or --
14 A. No, no. We did always speak about that, so that the
15 surgical specialist who had the longest wait got the 16:41
16 most operating sessions. We would have been faced with
17 lots of resistance from the other surgical specialists
18 who wanted to operate. They want their fair share of
19 operating time. So no, we did talk about it but
20 we never, I suppose, were brave enough to say, for 16:41
21 example to ENT, your waiting list is less. Apology,
22 that would be unfair. Gynaecology, your operating
23 time, your waiting time is less, we're going to take
24 two sessions off you and give it to urology. We didn't
25 do that. 16:42
26 309 Q. Should you have, do you think?
27 A. Pardon?
28 310 Q. Should you have?
29 A. Yes, if we're -- I'm not saying we weren't serious but

1 in terms of giving all patients the best service, then
2 clinically to have one speciality waiting X amount of
3 time and another surgical speciality X times three,
4 then those patients waiting longer were disadvantaged.
5 16:42
6 But I don't know any theatre in Northern Ireland who
7 operates like they do on the mainland. I remember
8 going to a conference in London and I remember a
9 hospital in Luton, and they operated on that principle.
10 So, the longest waiters got the most operating theatre. 16:43
11 311 Q. Just one thing on outpatient times in the same sort of
12 line. You elegantly displayed, I think it is 2016 we
13 were talking about, that there was an average of
14 between 300 and 425 new outpatient referrals a month
15 but only capacity for about 300. So there was 16:43
16 approximately about 100 extra patients a month that you
17 couldn't find slots for. Again, what was your response
18 to that?
19 A. Again, we would have met with the HSCB. Well, we would
20 have met with our own internal performance team and we 16:43
21 would discuss how we would have done that, how we would
22 have managed it. We would have discussed it -- we also
23 would have met with the HSCB, which is now the SPPBG
24 and they wouldn't have given us nonrecurrent monies to
25 run additional waiting lists -- sorry, additional 16:44
26 outpatient clinics. So, the consultants would have
27 undertaken that additional outpatients waiting list.
28 But it wasn't a permanent solution, it was
29 nonrecurrent, so you couldn't do anything substantive

1 in terms of making substantive appointments based on
2 nonrecurrent monies. It was a risky move. Some Trusts
3 did it but our Trust, we didn't do it.
4 312 Q. Thank you.
5 16:44
6 Just one thing on the PP analysis. A slightly unusual
7 situation that, from my reading, almost all the
8 patients start as NHS patients and were put on a
9 waiting list and then saw Mr. O'Brien in his private
10 rooms. Were they already on a surgical waiting list? 16:44
11 That wasn't well demonstrated in the analysis. This
12 has caused confusion, I think.
13 A. I am not sure. I don't know the answer, Mr. Hanbury,
14 in terms of patients were initially seen as an NHS
15 patient and subsequently went on to see Mr. O'Brien 16:45
16 privately, or they only saw Mr. O'Brien privately and
17 then were transferred into the Health Service. I don't
18 know the answer to that.
19 313 Q. But that would make a difference if they were?
20 A. Yes. 16:45
21 314 Q. Thank you.
22
23 Just lastly referring to Patient 16, sort of waiting
24 list issues, especially for scheduled patients, stent
25 change is delayed and that. 16:45
26 A. Yes.
27 315 Q. What mechanism did you have to oversee the waiting list
28 of a patient who has to wait a certain length of time,
29 but not shorter or longer, which is an unusual thing in

1 the case of a lot of urology patients?
2 A. So, Patient 16 required to have a stent removed in
3 order to have his chemotherapy. I suppose, as
4 Mr. Wolfe said, there was lots of miscommunication or
5 noncommunication between the Regional Oncology Centre 16:46
6 and the Trust. It was simply capacity to allow Patient
7 16 to allow to have the stents removed. He was caught
8 up in our inability to provide timely stent removal.
9 316 Q. Is that rather than having waiting list, clerical
10 office support-type factors in your thoughts? 16:46
11 A. I'm not too sure. Sorry?
12 317 Q. I was getting at the fact that Mr. O'Brien used to run
13 a lot of his waiting lists himself rather than relying
14 on clerical colleagues who may have assisted. Do you
15 think that was a problem? 16:47
16 A. Well, I know consultants obviously do -- if they don't
17 have the capacity and they're concerned about a
18 patient, they would speak to their colleague and say
19 would you operate on this patient for the following
20 reasons, and I'm sure nine times out of ten that 16:47
21 happens. I'm not aware that Mr. O'Brien made that
22 request of one of his colleagues for Patient 16.
23 318 Q. Thank you.
24 CHAIR: Just a couple of questions.
25 16:47
26 In one of your answers to Mr. Wolfe, you said that you
27 felt it was better that operational managers could
28 investigate the issues of concern regarding
29 Mr. O'Brien's practice if he were excluded rather than

1 him being there. Why was that?
2 A. I suppose -- and Mrs. Corrigan referred to that.
3 Mr. O'Brien is a big presence. It was not uncommon
4 that Mr. O'Brien would be in the hospital for many,
5 many, many hours, you know, well into the evening. 16:48
6 I met him when I was on-call sometimes walking the
7 corridors at maybe nine o'clock at night. So it was
8 generally felt his presence would just make things
9 easier.
10 319 Q. His absence, not his presence? 16:48
11 A. Sorry. His absence, yes.
12 320 Q. I suppose the corollary of that is why do you think
13 nobody sat down and talked to Mr. O'Brien about all of
14 this that was going on in the background, the MHPS
15 investigation? 16:48
16 A. I don't think anybody took ownership of it. I suppose
17 the management of Mr. O'Brien was through the MHPS
18 vehicle. That's a medically driven vehicle with
19 support of HR. I suppose from my perspective, I was
20 looking for senior clinicians to take the lead on it. 16:49
21 As I said, my knowledge of it was limited, very
22 limited. It's been my experience, working in the
23 Health Service many years, that senior clinicians
24 always interact better and communicate better with
25 their peers. Whilst I'm a senior manager and a nurse, 16:49
26 it's much more powerful and meaningful if an AMD or CD
27 or the Medical Director, but that didn't happen. I
28 suppose to answer your question why did that not
29 happen, I don't know.

1 321 Q. Was one of the factors perhaps the changeover of staff
2 in those roles?
3 A. In 2016?
4 322 Q. Hmm-mm.
5 A. Yes. Well, I think myself as one. Mrs. Trouton going 16:50
6 the other way.
7 323 Q. I'm thinking on the medical management side. I think
8 it went beyond 2016. There was a large turnover of
9 staff on the medical management side here.
10 A. Yes, yes. I think losing Dr. McAllister so early in 16:50
11 his tenure was unfortunate. I think that whilst we're
12 never know, my knowledge and experience of
13 Dr. McAllister would have made a difference or could
14 have made a difference. Then Mr. Weir being off sick
15 for extended periods of time over the next two years 16:50
16 again didn't help. Mr. Haynes coming in as the MD
17 in October 2018, and then his -- I think the term he
18 used is "Mr. O'Brien is a challenge". So, you know,
19 again he was a new MD finding his feet in the role. So
20 yes, I agree with you, the turnover of senior medics. 16:51
21 Also Dr. Khan, Dr. Wright, and the medical
22 directors didn't help. Dr. O'Kane coming in lately
23 didn't help either.
24 CHAIR: Thank you very much. I have no further
25 questions for you. I'm sure you will be very relieved 16:51
26 to know that we will hopefully not be asking you to
27 come back and talk to us on another day. Can I also
28 say I'm very sorry on your very recent bereavement as
29 well.

1
2 Ladies and gentlemen, tomorrow morning, 10 o'clock.
3
4 THE INQUIRY ADJOURNED TO 10:00 A.M. ON WEDNESDAY 19TH
5 APRIL 2023 16:51
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